Table of Contents

Medicaid State Plan Eligibility

Financial Eligibility Requirements for Non-MAGI Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

Package Header

Package ID	MD2018MS0006O	**SPA ID**	MD-18-0005
Submission Type	Official	**Initial Submission Date**	7/19/2018
Approval Date	3/15/2019	**Effective Date**	7/1/2018
Superseded SPA ID	NEW		
	User-Entered		

The state applies the following financial methodologies for all eligibility groups whose eligibility is not based on modified adjusted gross income (MAGI) rules (described in 42 C.F.R. §435.603):

A. Financial Eligibility Methodologies

☐ The state determines financial eligibility consistent with the methodologies described in 42 C.F.R. §435.601.

B. Eligibility Determinations of Aged, Blind and Disabled Individuals

Eligibility is determined for aged, blind and disabled individuals based on one of the following:

◉ SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

○ State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

○ State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

C. Financial Responsibility of Relatives

☐ The state determines the financial responsibility of relatives consistent with the requirements and methodologies described in 42 C.F.R. §435.602.

D. Additional Information (optional)

n/a

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

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Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19		☐	☐	○	CONVERTED
Parents and Other Caretaker Relatives		☐	☐	○	APPROVED
Pregnant Women		☐	☐	○	APPROVED
Deemed Newborns		☐	☐	○	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☐	☐	○	NEW
Former Foster Care Children		☐	☐	○	NEW
Transitional Medical Assistance		☐	☐	○	NEW
Extended Medicaid due to Spousal Support Collections		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
SSI Beneficiaries		☐	☐	○	NEW
Closed Eligibility Groups		☐	☐	○	NEW
Individuals Deemed To Be Receiving SSI		☐	☐	○	NEW
Working Individuals under 1619(b)		☐	☐	○	NEW
Qualified Medicare Beneficiaries		☐	☐	○	NEW
Qualified Disabled and Working Individuals		☐	☐	○	NEW
Specified Low Income Medicare Beneficiaries		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Qualifying Individuals					NEW

Mandatory Eligibility Groups

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B. The state elects the Adult Group, described at 42 CFR 435.119.

(•) Yes ( ) No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group					CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Parents and Other Caretaker Relatives

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

Package Header

Package ID	MD2018MS0006O	**SPA ID**	MD-18-0005
Submission Type	Official	**Initial Submission Date**	7/19/2018
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Superseded SPA ID	MD-13-0020-MM1		
	User-Entered		

The state covers the mandatory parents and other caretaker relatives group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☐ a. This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ b. Options relating to the definition of caretaker relative:

☐ c. Options relating to the definition of dependent child:

- ◉ i. The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.
- ○ ii. The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

2. Have household income at or below the standard established by the state.

Parents and Other Caretaker Relatives

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

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Superseded SPA ID	MD-13-0020-MM1		
	User-Entered		

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Income Standard Used

1. The income standard for this group is based on a percentage of the federal poverty level.

- (•) Yes
- ( ) No

2. The state uses the following income standard for this group: **FPL** 123.00%

Parents and Other Caretaker Relatives

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

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Superseded SPA ID	MD-13-0020-MM1		
	User-Entered		

D. Basis for Income Standard

1. Minimum Income Standard

a. The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in AFDC Income Standards.

☐ b. The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

2. Maximum income standard

☐ a. The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

b. The state's maximum income standard for this eligibility group is:

- ○ i. The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ◉ ii. The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ iii. The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ iv. The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

c. The amount of the maximum income standard is:

- ◉ i. A percentage of the federal poverty level: 123.00%
- ○ ii. The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.
- ○ iii. The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.
- ○ iv. The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in AFDC Income Standards.
- ○ v. Other dollar amount

Parents and Other Caretaker Relatives

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

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E. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

Women who are pregnant or post-partum, with household income at or below a standard established by the state.

Package Header

Package ID	MD2018MS0006O	**SPA ID**	MD-18-0005
Submission Type	Official	**Initial Submission Date**	7/19/2018
Approval Date	3/15/2019	**Effective Date**	7/1/2018
Superseded SPA ID	MD-17-0003		
	System-Derived		

The state covers the mandatory pregnant women group in accordance with the following provisions:

A. Characteristics

1. Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

2. Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 C.F.R. 435.110.

- (•) Yes
- ( ) No

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Income Standard Used

The state uses the following income standard for this group:

FPL	259.00%

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

Package Header

Package ID	MD2018MS0006O	**SPA ID**	MD-18-0005
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Superseded SPA ID	MD-17-0003		
	System-Derived		

D. Benefits for Pregnant Women

Benefits for individuals in this eligibility group consist of the following:

- (•) 1. All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- ( ) 2. Pregnant women whose income exceeds the income limit specified for full coverage of pregnant women receive only pregnancy-related services.

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

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Package ID MD2018MS0006O
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System-Derived

E. Basis for Pregnant Women Income Standard

1. Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

(•) Yes
( ) No

a. The amount of the minimum income standard (no higher than 185% FPL) is:

FPL 185.00%

2. Maximum income standard

[ ] a. The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

b. The state's maximum income standard for this eligibility group is:

( ) i. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

(•) ii. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) iii. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) iv. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) v. 185% FPL

c. The amount of the maximum income standard is: **FPL** 259.00%

G. Additional Information (optional)

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

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Package ID MD2018MS0006O
SPA ID MD-18-0005
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Initial Submission Date 7/19/2018
Approval Date 3/15/2019
Effective Date 6/1/2018
Superseded SPA ID NEW
User-Entered

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals. *

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	○	NEW
Reasonable Classifications of Individuals under Age 21		☐	☐	○	CONVERTED
Children with Non-IV-E Adoption Assistance		☐	☐	○	CONVERTED
Independent Foster Care Adolescents		☐	☐	○	CONVERTED
Optional Targeted Low Income Children		☐	☐	○	CONVERTED
Individuals above 133% FPL under Age 65		☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		☐	☐	○	NEW
Individuals Eligible for Family Planning Services		☐	☐	○	APPROVED
Individuals with Tuberculosis		☐	☐	○	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		☐	☐	○	NEW
Individuals Eligible for Cash Except for Institutionalization		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☐	☐	○	NEW
Optional State Supplement Beneficiaries		☐	☐	○	NEW
Individuals in Institutions Eligible under a Special Income Level		☐	☐	○	NEW
PACE Participants		☐	☐	○	NEW
Individuals Receiving Hospice		☐	☐	○	NEW
Children under Age 19 with a Disability		☐	☐	○	NEW
Age and Disability-Related Poverty Level		☐	☐	○	NEW
Work Incentives		☐	☐	○	NEW
Ticket to Work Basic		☐	☐	○	NEW
Ticket to Work Medical Improvements		☐	☐	○	NEW
Family Opportunity Act Children with a Disability		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	○	NEW

Optional Eligibility Groups

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Package Header

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Superseded SPA ID	NEW User-Entered		

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy. *

○ Yes ◉ No

Optional Eligibility Groups

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Approval Date	3/15/2019	**Effective Date**	6/1/2018
Superseded SPA ID	NEW		
	User-Entered		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for Family Planning Services

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

Individuals, regardless of gender, who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services.

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Superseded SPA ID	MD-13-0020-MM1		
	User-Entered		

The state covers the family planning eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are not pregnant

2. Are not otherwise eligible for and enrolled in mandatory coverage under the state plan

3. Are not otherwise eligible for and enrolled in optional full Medicaid coverage under the state plan

4. Have household income that does not exceed the income standard established by the state for this group

Individuals Eligible for Family Planning Services

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	User-Entered		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- (•) Yes
- ( ) No

Individuals Eligible for Family Planning Services

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Superseded SPA ID	MD-13-0020-MM1		
	User-Entered		

C. Income Standard Used

1. The state uses the same income standard for all individuals covered.

- (•) Yes
- ( ) No

2. The income standard for this eligibility group is:

259.00% FPL

Individuals Eligible for Family Planning Services

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

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	User-Entered		

D. Financial Methodologies

1. MAGI-based methodologies are used in calculating household income. Except as described in this section, for information on the methodology used for this group, please refer as necessary to MAGI-Based Methodologies, completed by the state.

2. The state uses the same financial methodology for all individuals covered.

- (•) Yes
- ( ) No

3. In determining eligibility for this group, the state includes the following household members:

- ( ) a. All household members
- (•) b. Only the individual

4. In determining eligibility for this group, the state increases the family size by one, counting the individual as two

- ( ) Yes
- (•) No

5. In determining eligibility for this group, the state counts the income of:

- ( ) a. All household members
- (•) b. Only the individual

Individuals Eligible for Family Planning Services

MEDICAID | Medicaid State Plan | Eligibility | MD2018MS0006O | MD-18-0005

Package Header

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Superseded SPA ID	MD-13-0020-MM1		
	User-Entered		

E. Basis for Income Standard - Maximum Income Standard

☐ 1. The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

2. The state's maximum income standard for this eligibility group is the highest of the following:

- ◉ a. The state's current effective income level for the Pregnant Women eligibility group (42 CFR 435.116) under the Medicaid state plan.
- ○ b. The state's current effective income level for pregnant women under a Medicaid 1115 Demonstration.
- ○ c. The state's current effective income level for Targeted Low-Income Pregnant Women under the CHIP state plan.
- ○ d. The state's current effective income level for pregnant women under a CHIP 1115 Demonstration.

3. The amount of the maximum income standard is:

259.00% FPL

F. Family Planning Benefits

Benefits for this eligibility group are limited to family planning and related services described in the Benefit and Payments section of the state plan.

G. Additional Information (optional)

n/a

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 3/25/2019 11:12 AM EDT

CMS-10434 OMB 0938-1188

Package Information

Package ID	MD2018MS0011O	**Submission Type**	Official
Program Name	Migrated_HH.MD HHS	**State**	MD
SPA ID	MD-18-0008	**Region**	Philadelphia, PA
Version Number	2	**Package Status**	Approved
Submitted By	Katia Fortune	**Submission Date**	8/20/2018
Package Disposition		**Approval Date**	10/16/2018 2:59 PM EDT
Priority Code	P2		

Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard, Mail Stop S2-14-26

Baltimore, Maryland 21244-1850

Date: 10/16/2018

Head of Agency: Robert Neall

Title/Dept : Secretary of Health

Address 1: 201 West Preston Street

Address 2:

City : Baltimore

State: MD

Zip: 21201

MACPro Package ID: MD2018MS0011O

SPA ID: MD-18-0008

Subject

MD 18-0008 Behavioral Health Home Rate Increase

Dear Robert Neall

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.

The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for

Behavioral Health Home Rate Increase SPA

Reviewable Unit	Effective Date
Health Homes Intro	7/1/2018
Health Homes Geographic Limitations	7/1/2018
Health Homes Population and Enrollment Criteria	7/1/2018
Health Homes Providers	7/1/2018
Health Homes Service Delivery Systems	7/1/2018
Health Homes Payment Methodologies	7/1/2018
Health Homes Services	7/1/2018
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2018

Increased Geographic Coverage

◯ Yes

◉ No

Increase in Conditions Covered

◯ Yes

◉ No

This SPA increases Behavioral Health, Health Home rates following Governor Hogan's approval for a 3.5 percent rate increase for the Maryland Medical Assistance, for dates of service beginning July 1, 2018. This represents an estimated $196,472 increase in total funds (50 percent general funds, $98,236, and 50 percent $98,236 federal funds).

Sincerely,

Alissa DeBoy

Mrs.

Approval Documentation

Name	Date Created	

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2018MS0011O | MD-18-0008 | Migrated_HH.MD HHS

Package Header

Package ID MD2018MS0011O

SPA ID MD-18-0008

Submission Type Official

Initial Submission Date 8/20/2018

Approval Date 10/16/2018

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Maryland

Medicaid Agency Name: Maryland Department of Health, Office of Health Care Financing

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2018MS0011O | MD-18-0008 | Migrated_HH.MD HHS

Package Header

Package ID MD2018MS0011O
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Initial Submission Date 8/20/2018
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SPA ID and Effective Date

SPA ID MD-18-0008

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	7/1/2018	16-0001
Health Homes Geographic Limitations	7/1/2018	16-0001
Health Homes Population and Enrollment Criteria	7/1/2018	16-0001
Health Homes Providers	7/1/2018	16-0001
Health Homes Service Delivery Systems	7/1/2018	16-0001
Health Homes Payment Methodologies	7/1/2018	16-0001
Health Homes Services	7/1/2018	16-0001
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2018	16-0001

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2018MS0011O | MD-18-0008 | Migrated_HH.MD HHS

Package Header

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SPA ID MD-18-0008

Submission Type Official

Initial Submission Date 8/20/2018

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Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives This SPA updates the reimbursement for Maryland Medical Assistance Behavioral Health, Health Home program. In accordance with Governor Hogan's rate increase for Maryland Medical Assistance, this proposal would increase the rates for Behavioral Health, Health Home program by 3.5 percent for dates of service beginning July 1, 2018. This represents an estimated $196,472 increase in total funds (50 percent general funds, $98,236, and 50 percent $98,236 federal funds).

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	$24559
Second	2019	$98236

Federal Statute / Regulation Citation

n/a

Submission - Summary

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SPA ID MD-18-0008
Submission Type Official
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Approval Date 10/16/2018
Effective Date N/A
Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Rebecca Frechard, LCPC
Director, Medicaid Behavioral Health Division
Office of Health Services

Submission - Public Comment

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Effective Date N/A
Superseded SPA ID N/A

Name of Health Homes Program

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Indicate whether public comment was solicited with respect to this submission.

- ○ Public notice was not federally required and comment was not solicited
- ○ Public notice was not federally required, but comment was solicited
- ◉ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☐ Email to Electronic Mailing List or Similar Mechanism
- ☐ Website Notice
- ☐ Public Hearing or Meeting
- ☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	
Public Notice	7/26/2018 10:31 AM EDT	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
No items available		

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

Submission - Tribal Input

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Name of Health Homes Program

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One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

- ( ) Yes
- (•) No

Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations

UIO expressed no concern, and had no comments (see attached document)

- (•) Even though not required, the state has solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA
- ( ) The state has not solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

- [ ] All Indian Health Programs
- [ ] All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
8/7/2018	email

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- [ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
MD 18-0008 Behavioral Health, Health Home Rate Increase UIO Approval	8/9/2018 11:54 AM EDT	PDF

Indicate the key issues raised (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility

- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Other Comment

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SAMHSA Consultation

Name of Health Homes Program

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☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
1/3/2013
2/15/2013

Health Homes Intro

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Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Migrated_HH.MD HHS

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Health Homes for individuals with chronic conditions augments the State's broader efforts to integrate somatic and behavioral health services, as well as aim to improve health outcomes and reduce avoidable hospital encounters. The program targets populations with behavioral health needs who are at high risk for additional chronic conditions, offering them enhanced care coordination and support services from providers with whom they regularly receive care. Health Homes are designed to enhance person-centered care, empowering participants to manage and prevent chronic conditions in order to improve health outcomes, while reducing avoidable hospital encounters. Several provider types are eligible to enroll as Health Homes, including psychiatric rehabilitation programs, mobile treatment service providers, and opioid treatment programs. Health Homes serve individuals who experience serious persistent mental illness (SPMI), serious emotional disturbance (SED), and those with opioid substance use disorders determined to be at risk for additional chronic conditions. Health Homes will receive a flat per member, per month payment to provide these services, as well as a one-time payment for each individual's initial intake assessment.

General Assurances

- [ ] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [ ] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [ ] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- [ ] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [ ] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- [ ] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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- (•) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

☐ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☐ Medically Needy Eligibility Groups

Mandatory Medically Needy

☐ Medically Needy Pregnant Women

☐ Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

☐ Medically Needy Children Age 18 through 20

☐ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☐ Medically Needy Aged, Blind or Disabled

☐ Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with

- [ ] Two or more chronic conditions
- [ ] One chronic condition and the risk of developing another

Specify the conditions included

- [ ] Mental Health Condition
- [ ] Substance Use Disorder
- [ ] Asthma
- [ ] Diabetes
- [ ] Heart Disease
- [ ] BMI over 25
- [ ] Other (specify)

Name	Description
Opioid Substance Use Disorder	Opioid Substance Use Disorder

Specify the criteria for at risk of developing another chronic condition

Eligibility criteria based on opioid substance use disorder:
1. The consumer has been diagnosed with an opioid substance use disorder.
2. The consumer must be engaged in opioid maintenance therapy.
3. The consumer is determined to be at risk for additional chronic conditions due to current tobacco, alcohol, or other non-opioid substance use, or a history of tobacco, alcohol, or other non-opioid substance dependence.

- [ ] One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

Eligibility criteria based on SPMI or SED:
1. The consumer has been diagnosed with SPMI or SED, meeting all relevant medical necessity criteria to receive psychiatric rehabilitation program (PRP) services or mobile treatment services (MTS).
2. The individual must be engaged in services with a PRP or MTS provider.
1. The consumer is not currently receiving either of the following services, considered duplicative of Health Home services:
a. 1915(i) waiver services
b. Targeted Mental Health Case Management

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- (•) Opt-In to Health Homes provider
- ( ) Referral and assignment to Health Homes provider with opt-out
- ( ) Other (describe)

Describe the process used

Health Homes may enroll an eligible individual to whom they provide PRP, MT, or OTP services, contingent upon participant consent, and in the case of OTP participants, the presence of an identified qualifying risk factor. Health Homes may enroll participants only after they have been enrolled for the provider's applicable PRP, MT, or OTP services, ensuring that all relevant medical necessity criteria has been met to confirm the qualifying diagnosis. Enrollment is complete upon submission of the participant's online eMedicaid intake. Consent will authorize sharing of information between identified service providers, the State, applicable Managed Care Organizations (MCOs) and Administrative Service Organizations (ASOs) for the purpose of improved care coordination and program evaluation. The Health Home will notify other treatment providers (e.g., primary care providers) of the participant's goals and the types of Health Home services the participant is receiving and encourage participation in care coordination efforts.

The State uses claims data to identify potentially-eligible consumers who could benefit from Health Home services. This includes individuals with a qualifying diagnosis who experience frequent emergency department usage, hospitalization, or increases in level of care. MCOs and the ASO may assist the State in the identification, outreach, and referral of potential participants among their own consumers. Upon obtaining consumer consent, the State, MCO, or ASO will refer individuals to a Health Home near their residence, at which point the Health Home may outreach to the consumer directly. The State engages additional referral sources to familiarize them with the Health Home's purpose and referral protocols, as well as alert them to opportunities for continued collaboration with Health Home providers. This may include hospitals and emergency departments, public agencies, and school-based health centers.

Health Homes Providers

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Types of Health Homes Providers

☐ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians

☐ Clinical Practices or Clinical Group Practices

☐ Rural Health Clinics

☐ Community Health Centers

☐ Community Mental Health Centers

☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

Health Homes must be licensed by the Department of Health and Mental Hygiene as a Psychiatric Rehabilitation Program (PRP), a Mobile Treatment Services (MTS) provider or an Opioid Treatment Program (OTP). In addition, providers must:

1) Be enrolled as a Maryland Medicaid Provider;
2) Be accredited by, or in the process of gaining accreditation from, an approved accrediting body offering a Health Home accreditation product.
3) For those agencies working with minors, demonstrate a minimum of 3 years of experience serving children and youth.

☐ Federally Qualified Health Centers (FQHC)

☐ Other (Specify)

☐ Teams of Health Care Professionals

☐ Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

All Health Homes must maintain staff in the ratios specified below whose time is exclusively dedicated to the planning and delivery of Health Home services.

1) Health Home Director: .5 FTE per 125 Health Home enrollees. Health Homes with less than 125 enrollees may employ 1 FTE individual to serve as both the Nurse Care Manager and Health Home Director, provided that individual is licensed and legally authorized to practice as a registered nurse. Health Homes requiring a Director at a level more than .5 FTE may choose to designate a lead Health Home Director and subsequent additional key management staff to fulfill the Director staffing requirement.

2) Health Home Care Manager: .5 full-time equivalent (FTE) per 125 Health Home enrollees. Among providers with more than 1 FTE Care Manager, the initial 1FTE care manager role must be filled by a nurse, while subsequent staff in this role may be physicians' assistants.

3) Physician or Nurse Practitioner Consultant: 1.5 hours per Health Home enrollee per 12 month period

4) Administrative Support Staff: The State estimates that Administrative Support Staff of approximately .25 FTE per 125 Health Home enrollees will be necessary to effectively implement the Health Home. However, because providers utilize a wide range of care management tools that may lessen the burden of administrative tasks, Health Homes may use their discretion in determining the staffing levels necessary to fulfill the administrative activities of the Health Home.

The staffing ratios specified as "per 125 Health Home enrollees" act as a minimum, requiring providers with less than 125 enrollees to maintain this level regardless of their enrollment. Smaller Health Homes may form a consortium to share Health Home staff and thus costs, although participants will be served at their own provider's location. Creation of such consortiums is contingent upon geographic proximity and State approval of an application addendum detailing the planned collaboration.

Although the aforementioned staffing must be dedicated exclusively to Health Home activities, qualified staff members within the PRP, MT or OTP—such as licensed counselors or nurses—may provide Health Home services as well. It is expected that all staff members, not only those dedicated exclusively to the Health Home, will be fully informed of the goals of the Health Home and collaborate to serve participants.

Health Homes Providers

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Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

To encourage ongoing information-sharing and problem-solving between Health Homes, the Department offers educational opportunities such as webinars and regional meetings. Additionally, regular communication and feedback between the State and individual Health Homes facilitates a collaborative and responsive working relationship. The Maryland Department of Health closely monitors Health Home providers to ensure their services meet Maryland's Health Home standards as well as CMS' Health Home core functional requirements stated above. Oversight activities may include medical chart and care management record review, site audits, and team composition analysis. The State performs outreach to providers and agencies that may collaborate with Health Homes for the benefit of patients, informing them of the Health Home objectives and role in order to foster these linkages.

Health Homes Providers

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Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

A Health Home serves as the central point for directing person-centered care with the goal of improving patient outcomes while reducing avoidable health care costs. While providers are afforded a degree of flexibility in the design and implementation of their Health Homes, they must meet certain requirements in addition to those delineated above. These standards are detailed below.

Initial Provider Qualifications
1. Health Home providers must be enrolled in the MD Medicaid program as a PRP,OTP, or Mobile Treatment provider and agree to comply with all Medicaid program requirements.

2. Health Home providers must have, or demonstrate their intention to pursue, accreditation from an approved body offering a Health Home accreditation product.

3. Health Home providers must directly provide, or subcontract for the provision of, Health Home services. The Health Home provider remains responsible for all Health Home program requirements, including services performed by the subcontractor.

4. Health Homes providing PRP or MT services to minors must demonstrate a minimum of 3 years of experience providing services to children and youth.

5. Health Homes must ensure a minimum of one Health Home director and one Care Manager are in place before beginning service provision, and must reach all required staffing levels within 30 days of beginning service provision.

6. Health Homes must provide services to all Health Home enrollees, with each individual's care under the direction of a dedicated care manager accountable for ensuring access to medical and behavioral health care services and community social supports as defined in the participant's care plan.

7. Providers must complete an application to the State demonstrating their ability to perform each of the CMS Health Home core functional components (refer to section Support for Providers). Providers must propose a set of systems and protocols, including:
a. processes used to perform these functions;
b. processes and timeframes used to assure service delivery takes place in the described manner; and
c. descriptions of multifaceted Health Home service interventions that will be provided to promote patient engagement, participation in their plan of care, and that ensures patients appropriate access to the continuum of physical and behavioral health care and social services.

8. Health Homes must participate in federal and state-required evaluation activities including documentation of Health Home service delivery as well as clients' health outcomes and social indicators in the eMedicaid online portal.

9. Providers must maintain compliance with all of the terms and conditions as a Health Home provider or will be discontinued as a provider of Health Home services. In the event of any recovery of funds resulting from a provider termination, the FMAP portion of funds recovered will be returned to CMS in accordance with standard protocols.

10. Providers that wish to disenroll as a Health Home must notify the State of their intent with at least 30 days notice prior to discontinuing services. They must inform Health Home participants that they will no longer provide Health Home services, and that these may be obtained elsewhere if the participants wish to transfer their care.

Ongoing Provider Qualifications
Following enrollment, Health Home providers must also:

1. Enroll with Chesapeake Regional Information System for our Patients (CRISP) to receive hospital encounter alerts and access pharmacy data;

2. Convene and document internal Health Home staff meetings every 6 months, at minimum, to plan and implement goals and objectives of practice transformation.

3. Complete a program assessment process every six months confirming that the Health Home meets all staffing and regulatory requirements, and demonstrating a quality improvement plan to address gaps and opportunities for improvement; and

4. Obtain accreditation from an approved accrediting body offering a Health Home accreditation product within 18 months of initiating the accreditation process, or demonstrate significant progress towards this goal.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [ ] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

☐ Fee for Service

☐ Individual Rates Per Service

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

Describe below

Health Homes may receive a one-time reimbursement for the completion of each participants' initial intake and assessment necessary for enrollment into the Health Home. The payment will be the same as the rate paid for monthly services on a per-member basis.
The monthly rate is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland, including the provision of a minimum of two services in the month. The Health Homes are not paying any monies to other providers. There is only one exchange of payment and that is from the State to the Health Home providers.
Health Home providers must document services and outcomes within the participant's file and in eMedicaid. These documents are accessible to the Department and the Department's designees through eMedicaid and are auditable.
Rates are reviewed annually.
Health Home participants may only be enrolled in one Health Home at a time. If participant is enrolled in a Health Home, Maryland's system automatically blocks the participant from being enrolled in another Health Home.

Health Homes will be paid a monthly rate based on the employment costs of required Health Home staff, using salary and additional employment cost estimates for each of the required positions and their respective ratios. Payment is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland. Failure to meet such requirements is ground for payment sanctions or revocation of Health Home status.
The Department does not pay for

separate billing for services which are included as part of another service. At the end of each month, Health Homes will ensure that all Health Home services and outcomes have been reported into eMedicaid. The provider will then submit a bill within 30 days for all participants that received the minimum Health Home service requirement in the preceding month. The provider may begin billing for a Health Home participant when the intake portion of that individual's eMedicaid file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The initial intake process itself qualifies as a Health Home service. The ongoing criteria for receiving a monthly payment is:
1. The individual is identified in the State's Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;
2. The individual was enrolled as a Health Home member with the Health Home provider in the month for which the provider is submitting a bill for Health Home services; and
3. The individual has received a minimum of two Health Home services in the previous month, which are documented in the eMedicaid system.
The agency's fee schedule (rate) was last updated on July 1, 2018 and is effective for services provided on or after that date. Effective July 1, 2018 the Health Home rate will be increased 3.5% bringing the rate to $100.85.

☐ Per Member, Per Month Rates

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

There are no variations in payment.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

Jul 1, 2018

Website where rates are displayed

health.maryland.gov/providerinfo

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Behavioral Health rates are typically reviewed and updated for inflation annually. This program was added to that annual review process in FY 2017.
Effective July 1, 2016 the Health Home rate will be increased 2% bringing the rate to $100.85. This change is being submitted to CMS through a separate process, with public notice being published June 10th. MD then increased the rate by 3.5% in 2018. There is no tiered payment for this service. All Health Homes receive the same monthly rate if they perform the minimum number of services for that individual.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2018MS0011O | MD-18-0008 | Migrated_HH.MD HHS

Package Header

Package ID MD2018MS0011O

SPA ID MD-18-0008

Submission Type Official

Initial Submission Date 8/20/2018

Approval Date 10/16/2018

Effective Date 7/1/2018

Superseded SPA ID 16-0001

User-Entered

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MD2018MS0011O | MD-18-0008 | Migrated_HH.MD HHS

Package Header

Package ID	MD2018MS0011O	**SPA ID**	MD-18-0008
Submission Type	Official	**Initial Submission Date**	8/20/2018
Approval Date	10/16/2018	**Effective Date**	7/1/2018
Superseded SPA ID	16-0001		
	User-Entered		

Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Health Home staff collaborate to provide comprehensive care management services with active patient and family participation. The Health Home coordinates primary and behavioral health care and social services to address the whole-person needs of patients at the individual and population levels. This includes the following:
a. Initial assessment: The Health Home conducts, or provides a referral to the PCP for, a comprehensive biopsychosocial assessment, if no such assessment has been performed by a licensed physician or nurse practitioner in the preceding 6-month period.
b. Development of Care plan: Using the initial assessment and PCP records as available, the Health Home team works with the participant to develop an ITP including goals and timeframes, community networks and supports, and optimal clinical outcomes.
c. Delineation of roles: The Health Home assigns each team member clear roles and responsibilities. Participant ITPs identify the various providers and specialists within and outside the Health Home involved in the consumer's care.
d. Monitoring and reassessment: The Health Home monitors individual health status and progress towards ITP goals, documenting changes and adjusting care plans as needed, twice annually minimally.
e. Outcomes and Reporting: The Health Home uses the eMedicaid portal and other available HIT tools possibly including EHR, to review and report quality metrics, assessment and survey results, and service utilization in order to evaluate client satisfaction, health status, service delivery, and costs.
f. Population-based Care Management: Providers monitor population health status and service use to determine adherence to or variance from treatment guidelines. The Health Home identifies and prioritizes and population-wide needs and trends, then implement appropriate population-wide treatment guidelines and interventions.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Homes have access to the State's online eMedicaid portal, allowing providers to report and review participant intake, assessment, assigned staff, ITP, clinical baselines and data relating to chronic conditions, as well as Health Home services provided, such as referrals made and health promotion activities completed. eMedicaid generates reports of the aforementioned data at a participant or provider level. Additional access to hospital encounter and pharmacy data through the Chesapeake Regional Information System for Our Patients (CRISP) Electronic Notification System will enable Health Homes to gain a more comprehensive understanding to their participants' care and health status.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Opioid Treatment Program Clinical Supervisors, Licensed Mental Health Professionals, and PRP Rehabilitation Specialists and PRP Direct Support Staff may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Clinical Supervisors may also play a role in population-based care management tasks.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Coordinators may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Nurse Care Coordinators may also play a role in population-based care management tasks.

☐ Nurses

Description

Nurses may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Nurse Practitioners may perform the initial biopsychosocial assessment of a new Health Home participant, as well as play in role in population-based care management.

☐ Medical Specialists

☐ Physicians

Description

Physicians may perform the initial biopsychosocial assessment of a new Health Home participant, as well as participate in development and ongoing monitoring and reassessment of the ITP goals. Physicians may also play a role in population-based care management tasks.

☐ Physician's Assistants

Description

Physicians' Assistants may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment.

- [ ] Pharmacists
- [ ] Social Workers

Description

Social Workers may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Health Home Director	The Health Home Director may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. They may also take part in population-based care management activities.

Care Coordination

Definition

Care coordination includes implementation of the consumer-centered ITP through appropriate linkages, referrals, coordination and follow-up to needed services and support. Specific activities include: appointment scheduling, referrals and follow-up monitoring, tracking of appropriate screenings and EPDST needs, and communication with other providers and supports. Health Homes serving children place particular emphasis on coordination with school officials, PCPs, and involved agencies such as DSS.
The Health Home provider assigns each enrollee a Care Manager who will be responsible for coordinating the individuals' care and ensuring implementation of the treatment plan in partnership with the individual and family, as appropriate.
At the population level, the Health Home provider develops policies and procedures to facilitate collaboration between primary care, specialist, and behavioral health providers, as well as agencies and community-based organizations; and for children, school-based providers. Such policies will clearly define the roles and responsibilities of each in order to ensure timely communication, use of evidence-based referrals, follow-up consultations, and regular case review meetings with all members of the Health Home team. The Health Home ensures that all regular screenings and immunizations are conducted through coordination with the primary care or other appropriate provider. In addition, members of the Health Home team meets with area providers to enhance collaboration and integration with regard to the population.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The eMedicaid online portal allows Health Homes to report and review referrals made to outside providers, social and community resources, and individual and family supports. Access to CRISP hospital encounter alerts will facilitate prompt discharge planning and follow-up. As the State continues to develop eMedicaid's capabilities, claims data may ultimately populate fields in the eMedicaid system, allowing Health Home providers to better track their participant needs, services received, and identify opportunities for improved care coordination.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

Appropriate behavioral health professionals or specialists- including Addictions Counselors, OTP Clinical Supervisors, PRP Rehabilitation Specialists, and PRP Direct Support Staff- may provide care coordination services.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

Nurse Care Coordinators may provide care coordination services.

- [ ] Nurses

Description

Nurses may provide care coordination services.

- [ ] Medical Specialists
- [ ] Physicians

Description

Physicians may provide care coordination services.

- [ ] Physician's Assistants

Description

Nurse Care Coordinators may provide care coordination services.

- [ ] Pharmacists
- [ ] Social Workers

Description

Social Workers may provide care coordination services.

- [ ] Doctors of Chiropractic

- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Administrative Support Staff	Administrative Support Staff may provide care coordination services in the form of appointment scheduling and tracking.

Health Promotion

Definition

Health Promotion services assist patients and families to participate in the implementation of their care plan and place a strong emphasis on skills development for monitoring and management of chronic and other somatic health conditions. Health promotion services will include health education and coaching specific to an individual's condition(s), development of a self-management goals, medication review and education, and promotion of healthy lifestyle interventions. Such interventions may include, those that encourage substance use and smoking prevention or cessation, improved nutrition, obesity prevention and reduction, and increased physical activity.

Health Homes working with children will emphasize these preventive health initiatives, while actively involving parents and families in the process. This will include identifying conditions for which the child may be at risk due to family, physical, or social factors, and working with the patient and caregivers to address these areas.

At the population level, the Health Home team will use data to: identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions; and modify them accordingly.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home providers will use the eMedicaid portal to document, review, and report health promotion services delivered to each enrollee. Additionally, periodic updates to clinical outcomes may be reported in tandem with the related health promotion services delivered—for example, while reporting a discussion regarding physical activity in the eMedicaid portal, the Health Home would note the participant's weight and BMI.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

  Description

  As appropriate, the following providers may perform or assist with health promotion services: Addictions Counselors, PRP Rehabilitation Specialists, Licensed Mental Health Professionals, OTP Clinical Supervisors and PRP Direct Support Staff.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

  Description

  Nurse Care Coordinators may perform health promotion services.

- [ ] Nurses

  Description

  Nurses may perform health promotion services.

- [ ] Medical Specialists
- [ ] Physicians

  Description

  Physicians may perform health promotion services.

- [ ] Physician's Assistants

  Description

  Physicians' Assistants may perform health promotion services.

- [ ] Pharmacists
- [ ] Social Workers

  Description

  As appropriate, Social Workers may perform health promotion services.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Health Homes provide services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, interrupt patterns of frequent hospital emergency department use, and ensure timely and proper follow up care. The Health Home increases consumers' and

family members' ability to manage care and live safely in the community, shifting the use of reactive care and treatment to proactive health promotion and self-management.

Transitional care services vary by age of participants, and may include transitions to or from residential care facilities. Among transitional-age youth, services address the needs of participants and families as the individuals approach a shift into adult services and programs.

To accomplish these functions, providers establish a clear protocol for responding to CRISP alerts or notification from any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Care Managers will follow up with consumers within two business days post-discharge discharge via home visit, phone call, or scheduling an on-site appointment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Homes are required to enroll with CRISP in order to receive alerts of hospital admissions, discharges, or transfer among their Health Home patient panel. Real-time access to this information will allow Health Home providers to provide prompt coordination and follow-up care. This ability will be augmented by real-time access to pharmacy data that may aid in medication reconciliation.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

As appropriate, the following providers may deliver or assist in the delivery of comprehensive transitional care services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, PRP Direct Support Staff.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

Nurse Care Managers may provide comprehensive transitional care services.

- [ ] Nurses

Description

Nurses may provide comprehensive transitional care services.

- [ ] Medical Specialists
- [ ] Physicians

Description

Physicians may provide comprehensive transitional care services.

- [ ] Physician's Assistants

Description

Physicians' Assistants may provide comprehensive transitional care services.

- [ ] Pharmacists
- [ ] Social Workers

Description

Social Workers may provide comprehensive transitional care services.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Health Home Directors	Health Home Directors may provide comprehensive transitional care services.

Individual and Family Support (which includes authorized representatives)

Definition

Services include advocating for individuals and families; assisting with medication and treatment adherence; identifying resources for individuals and families to support them in attaining their highest level of health and functioning, including transportation to medically-necessary services; improving health literacy; increasing the ability to self-manage care; facilitating participation in the ongoing revision of care/treatment plan; and providing information as appropriate on advance directives and health care power of attorney. Health Homes connect participants with peer support services, many of which will be offered on-site, as well as referring participants to support groups and self-care programs as appropriate.

At the population level, services include: collecting and analyzing individual and family needs data; developing individual and family support materials and groups regarding the areas listed above; soliciting community organizations to provide group support to the population; and providing training and technical assistance as needed regarding the special needs of and effective interventions for the population.

The Health Home provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregivers, as appropriate, is language, literacy and culturally appropriate.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The eMedicaid tool allows Health Home providers to document, review, and report individual and family support services delivered, including referrals to outside groups or programs. Using real-time pharmacy data, Health Home providers are better able to assist individuals in obtaining and adhering to prescription medications.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

As appropriate, the following providers may deliver or assist in the delivery of individual and family support services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, and PRP Direct Support Staff.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Coordinators may provide individual and family support services.

☐ Nurses

Description

Nurses may provide individual and family support services.

☐ Medical Specialists

☐ Physicians

Description

Physicians may provide individual and family support services.

☐ Physician's Assistants

Description

Physicians' Assistants may provide individual and family support services.

☐ Pharmacists

☐ Social Workers

Description

Social Workers may provide individual and family support services.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Referral to Community and Social Support Services

Definition

The Health Home will identify available community-based resources and actively manage appropriate referrals, access to care, and engagement with other community, social, and school-based supports. Specific services will include: providing assistance for accessing Medical Assistance, disability benefits, subsidized or supported housing, personal needs support, peer or family support, and legal services, as appropriate. The Health Home will assist in coordinating these services and following up with consumers post service engagement.

At the population level, the Health Home team will: develop and monitor cooperative agreements with community and social support agencies that establish collaboration, follow-up, and reporting standards; recruit agencies to enter into those collaborative agreements; and provide training and technical assistance as needed regarding the special needs of and effective interventions for the population.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Using the eMedicaid online portal, Health Home providers may document, report, and review referrals to community-based resources.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

The following providers may provide referrals to community and social support services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, and PRP Direct Support Staff.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Coordinators may provide referrals to community and social support services.

☐ Nurses

Description

Nurses may provide referrals to community and social support services.

- [ ] Medical Specialists
- [ ] Physicians

Description

Physicians may provide referrals to community and social support services.

- [ ] Physician's Assistants

Description

Physicians' Assistants may provide referrals to community and social support services.

- [ ] Pharmacists
- [ ] Social Workers

Description

Social Workers may provide referrals to community and social support services.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Health Home Director	The Health Home Director may provide referrals to community and social support services.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MD2018MS0011O | MD-18-0008 | Migrated_HH.MD HHS

Package Header

Package ID	MD2018MS0011O	**SPA ID**	MD-18-0008
Submission Type	Official	**Initial Submission Date**	8/20/2018
Approval Date	10/16/2018	**Effective Date**	7/1/2018
Superseded SPA ID	16-0001		
	User-Entered		

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Referral & Enrollment
Potential Health Home participants may be informed of and referred to a Health Home in their region by a variety of sources. Upon engaging with a potential participant, the Health Home enrolls the individual in the appropriate PRP, MT, or OTP services for which they are eligible, and in the case of OTP patients, identify the qualifying risk factors that place them at risk for additional chronic conditions. The Health Home then explains the data-sharing elements of the program and obtain consent from the participant. Finally, the provider creates an entry and intake for the participant in the eMedicaid system, effectively enrolling them in the Health Home.

Participation
While participating in the Health Home, an individual will receive a minimum of two Health Home services per month, to be documented in the eMedicaid portal. A Care Manager will monitor their care and health status, and the Health Home team will assist with the provision of Health Home services as necessary. The Health Home will periodically reassess participants, and in doing so determine whether Health Home services are necessary.

Discharge
Discharge from the Health Home will primarily result from incidents such as relocation, incarceration, or loss of eligibility. In such cases, the Health Home provider will follow discharge protocol appropriate to the circumstances. In such cases where an individual 's PRP, MT, or OTP services cease due to stabilization or reaching age 18, they may remain in the Health Home for six months, during which the Health Home provider will emphasize support their transition to the appropriate level of care. Discharge planning may include the development of a discharge plan with referrals to the appropriate services and providers which will continue the individual's care and support. The Health Home provider will report in eMedicaid the discharge of a participant, as well as note the completion of discharge planning.

Name	Date Created	
Health Home Participant Flow Chart (MACPRO upload)	7/27/2018 1:33 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MD2018MS0011O | MD-18-0008 | Migrated_HH.MD HHS

Package Header

Package ID	MD2018MS0011O	**SPA ID**	MD-18-0008
Submission Type	Official	**Initial Submission Date**	8/20/2018
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Superseded SPA ID	16-0001		
	User-Entered		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

Using claims data, the State tracks avoidable hospital readmissions by calculating ambulatory care sensitive conditions (ACSC) readmissions per 1000 enrollees. To calculate this rate: (# of readmissions with a primary diagnosis consisting of an Agency of Healthcare Research and Quality (AHRQ) ICD-9 code for ambulatory care sensitive conditions/member months) x 12,000.
To measure cost savings generated by Chronic Health Homes, the State may compare the costs per member per month for participants by Health Home provider and by condition to costs for comparison groups of OTP, MT, and PRP participants enrolled with non-Health Home providers. The State may also compare overall costs between the groups for emergency room utilization, hospitalizations, nursing facility admissions, and pharmacy utilization. In this assessment, the State may review each Chronic Health Home independently for its overall costs and the allocation of its funds amongst services provided to inform future implementation and process modifications.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

1.eMedicaid Portal: eMedicaid is a web-based portal accessible to all networks, allowing Health Home providers to record and review of services delivered as well as clinical and social outcomes related to the individuals' chronic conditions. The portal is secure, with Health Homes' access limited to access the records of their own current enrollees. The State uses eMedicaid reports to track enrollment, compliance, and outcomes at the provider and population levels.

2.Chesapeake Regional Information System for our Patients (CRISP): All Health Home providers must enroll with CRISP's Electronic Notification System to receive hospital encounter alerts. This entails an initial upload of the Health Home's patient panel with all necessary demographic information, followed by monthly panel updates, as well as the set up of a direct message inbox and/or an interface with the provider's EHR to receive alerts.

3.Pharmacy Data: CRISP will additionally provide pharmacy data to Health Homes, including all Schedule II-V through the State's Prescription Drug Monitoring Program (PDMP), as well as any prescription drug within the Surescripts network.

4.Electronic Health Records (EHR) and Clinical Management Systems:Qualification as a Health Home provider is in part dependent upon the ability to report detailed performance metrics, measure improvement in care coordination, and gauge clinical outcomes on a provider level. Providers who do not currently use a robust EHR or clinical management system may determine that such a tool is necessary to meet the reporting and care coordination requirements of the Health Home program, as well as to improve their overall care capabilities.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MD2018MS0011O | MD-18-0008 | Migrated_HH.MD HHS

Package Header

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	User-Entered		

Quality Measurement and Evaluation

- [ ] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- [ ] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- [ ] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- [ ] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 10/16/2018 7:50 PM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID MD2019MS0001O

Submission Type Official

Approval Date 9/5/2019

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Initial Submission Date 7/15/2019

Effective Date N/A

SPA ID and Effective Date

SPA ID MD-19-0004

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Optional Eligibility Groups	10/1/2019	MD-18-0005
Individuals Receiving State Plan Home and Community-Based Services	10/1/2019	New

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID MD2019MS0001O

SPA ID MD-19-0004

Submission Type Official

Initial Submission Date 7/15/2019

Approval Date 9/5/2019

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

The State of Maryland is pleased to submit State Plan Amendment 19-0003 1915(i) Home and Community-Based Services Administration and Operations. In accordance with Medicaid's proposed 1915i waiver renewal, this proposal would amend the services and eligibility requirements of the 1915i program to expand access to necessary behavioral health services. Maryland is requesting an effective date of October 1, 2019.

Maryland predicts a federal fiscal impact of $0 for Federal Fiscal year 2018 and Federal Fiscal Year 2019, respectively.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	$0
Second	2020	$0

Federal Statute / Regulation Citation

N/A

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID MD2019MS0001O

SPA ID MD-19-0004

Submission Type Official

Initial Submission Date 7/15/2019

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Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Dennis Schrader, Medicaid Director, Maryland Department of Health

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID	MD2019MS0001O	**SPA ID**	MD-19-0004
Submission Type	Official	**Initial Submission Date**	7/15/2019
Approval Date	9/5/2019	**Effective Date**	N/A
Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- (•) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- ( ) Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID MD2019MS0001O

SPA ID MD-19-0004

Submission Type Official

Initial Submission Date 7/15/2019

Approval Date 9/5/2019

Effective Date N/A

Superseded SPA ID N/A

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (•) Yes
- ( ) No

[ ] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

[ ] All Indian Health Programs

[ ] All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
3/28/2019	Email

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

[ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
UIO Approval MD SPA 19-0003 1915i SPA	7/15/2019 2:42 PM EDT	

Indicate the key issues raised (optional)

[ ] Access

[ ] Quality

[ ] Cost

[ ] Payment methodology

[ ] Eligibility

[ ] Benefits

[ ] Service delivery

[ ] Other issue

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID MD2019MS0001O
SPA ID MD-19-0004
Submission Type Official
Initial Submission Date 7/15/2019
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Effective Date 10/1/2019
Superseded SPA ID MD-18-0005
System-Derived

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	○	NEW
Reasonable Classifications of Individuals under Age 21		☐	☐	○	CONVERTED
Children with Non-IV-E Adoption Assistance		☐	☐	○	CONVERTED
Independent Foster Care Adolescents		☐	☐	○	CONVERTED
Optional Targeted Low Income Children		☐	☐	○	CONVERTED
Individuals above 133% FPL under Age 65		☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		☐	☐	○	NEW
Individuals Eligible for Family Planning Services		☐	☐	○	APPROVED
Individuals with Tuberculosis		☐	☐	○	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		☐	☐	○	NEW
Individuals Eligible for Cash Except for Institutionalization		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules					NEW
Optional State Supplement Beneficiaries					NEW
Individuals in Institutions Eligible under a Special Income Level					NEW
PACE Participants					NEW
Individuals Receiving Hospice					NEW
Children under Age 19 with a Disability					NEW
Age and Disability-Related Poverty Level					NEW
Work Incentives					NEW
Ticket to Work Basic					NEW
Ticket to Work Medical Improvements					NEW
Family Opportunity Act Children with a Disability					NEW
Individuals Receiving State Plan Home and Community-Based Services					APPROVED
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers					NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID	MD2019MS0001O	**SPA ID**	MD-19-0004
Submission Type	Official	**Initial Submission Date**	7/15/2019
Approval Date	9/5/2019	**Effective Date**	10/1/2019
Superseded SPA ID	MD-18-0005		
	System-Derived		

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		☐	☐	○	NEW
Medically Needy Children under Age 18		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Protected Medically Needy Individuals Who Were Eligible in 1973		☐	☐	○	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Populations Based on Age, Blindness or Disability		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID	MD2019MS0001O	**SPA ID**	MD-19-0004
Submission Type	Official	**Initial Submission Date**	7/15/2019
Approval Date	9/5/2019	**Effective Date**	10/1/2019
Superseded SPA ID	MD-18-0005		
	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Receiving State Plan Home and Community-Based Services

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Individuals receiving section 1915(i) state plan home and community-based services.

Package Header

Package ID	MD2019MS0001O	**SPA ID**	MD-19-0004
Submission Type	Official	**Initial Submission Date**	7/15/2019
Approval Date	9/5/2019	**Effective Date**	10/1/2019
Superseded SPA ID	New User-Entered		

The state covers the optional Individuals Receiving State Plan Home and Community-Based Services eligibility group in accordance with the following provisions:

☐ Individuals who are eligible under other eligibility groups receive section 1915(i) home and community-based services under the state plan.

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Meet the needs-based criteria for receiving home and community-based services specified in section 1915(i)(1) of the Act and at 42 CFR 441.715. These are defined in the benefits section of the state plan.

2. Have income that does not exceed the standard described in section D.

3. Will receive at least one state plan home and community-based service as defined at 42 CFR 440.182.

Individuals Receiving State Plan Home and Community-Based Services

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID	MD2019MS0001O	**SPA ID**	MD-19-0004
Submission Type	Official	**Initial Submission Date**	7/15/2019
Approval Date	9/5/2019	**Effective Date**	10/1/2019
Superseded SPA ID	New		
	User-Entered		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

(•) Yes ( ) No

Individuals Receiving State Plan Home and Community-Based Services

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID MD2019MS0001O
SPA ID MD-19-0004
Submission Type Official
Initial Submission Date 7/15/2019
Approval Date 9/5/2019
Effective Date 10/1/2019
Superseded SPA ID New

User-Entered

C. Financial Methodologies

1. The state uses the same financial methodology for all individuals covered.

(•) Yes ( ) No

2. The financial methodology used is:

SSI methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

Less restrictive methodologies are used in calculating countable income.

(•) Yes ( ) No

The less restrictive income methodologies are:

[ ] The difference between one income standard and another is disregarded.

(•) Between the following percentages of the FPL:
FPL 150.00%
and
FPL 300.00%

( ) Between the medically needy income limit and a percentage of the FPL:

( ) Between the SSI Federal Benefit Rate and:

( ) Between other income standards:

[ ] Less restrictive methodologies are used with respect to self-employment income.

[ ] A standard disregard is used instead of actual expenses if it is to the individual's benefit.

The amount of the standard disregard is: (•) A percentage of the gross receipts: ( ) A dollar amount:

Percentage: 50.00%

[ ] Census Bureau wages are disregarded.

Description of disregard: Census Bureau wages are disregarded.

[ ] Interest is disregarded.

Description of disregard: Interest is disregarded.

[ ] Training allowances and expenses are disregarded.

Description of disregard: Training allowances and expenses are disregarded.

[ ] Room and/or board from a person living in the individual's home is disregarded.

Description of disregard: Room and board from a person living in the individual's home is disregarded.

[ ] A specified type of income is disregarded:

Name of income type:	Description:
Charitable contributions	Charitable contributions.

[ ] The following less restrictive methodologies are used:

Name of methodology:	Description:
Infrequent/irregular income.	For unearned income up to $200 over 6 months and for earned income $30/quarter.

Individuals Receiving State Plan Home and Community-Based Services

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID	MD2019MS0001O	**SPA ID**	MD-19-0004
Submission Type	Official	**Initial Submission Date**	7/15/2019
Approval Date	9/5/2019	**Effective Date**	10/1/2019
Superseded SPA ID	New User-Entered		

D. Income Standard Used

1. The state uses the same income standard for all individuals covered.

(•) Yes ( ) No

2. The income standard for this eligibility group is:

(•) a. 150% FPL

( ) b. A lower percent of the FPL:

Individuals Receiving State Plan Home and Community-Based Services

MEDICAID | Medicaid State Plan | Eligibility | MD2019MS0001O | MD-19-0004

Package Header

Package ID	MD2019MS0001O	**SPA ID**	MD-19-0004
Submission Type	Official	**Initial Submission Date**	7/15/2019
Approval Date	9/5/2019	**Effective Date**	10/1/2019
Superseded SPA ID	New		
	User-Entered		

E. Resource Standard Used

There is no resource test for this group.

F. Additional Information (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 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 9/5/2019 2:14 PM EDT

MD - Submission Package - MD2019MS0002O - (MD-19-0009) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	MD2019MS0002O	**Submission Type**	Official
Program Name	Migrated_HH.MD HHS	**State**	MD
SPA ID	MD-19-0009	**Region**	Philadelphia, PA
Version Number	1	**Package Status**	Approved
Submitted By	Katia Fortune	**Submission Date**	9/27/2019
Package Disposition		**Approval Date**	10/29/2019 3:56 PM EDT
Priority Code	P2		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Philadelphia Regional Office
150 S. Independence Mall West, Suite 216, The Public Ledger Building
Philadelphia, PA 9106-34991

Division of Medicaid and Children's Health Operations

October 29, 2019

Mr. Dennis Schrader
Medicaid Director
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201

Re: Approval of State Plan Amendment MD-19-0009 Migrated_HH.MD HHS

Dear Mr. Dennis Schrader :

On September 27, 2019, the Centers for Medicare and Medicaid Services (CMS) received Maryland State Plan Amendment (SPA) MD-19-0009 for Migrated_HH.MD HHS to This amendment increases the rates for the Behavioral Health, Health Home program, by 3.5 percent, for dates of service beginning July 1, 2019.

We approve Maryland State Plan Amendment (SPA) MD-19-0009 on October 29, 2019 with an effective date(s) of July 01, 2019.

Name	Date Created	
No items available		

If you have any questions regarding this amendment, please contact Talbatha Myatt at talbatha.myatt@cms.hhs.gov.

Sincerely,

Francis T. McCullough

Director
Division of Medicaid Field Operations East
Regional Operations Group

Division of Medicaid and Children's Health Operations

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2019MS0002O | MD-19-0009 | Migrated_HH.MD HHS

Package Header

Package ID MD2019MS0002O
SPA ID MD-19-0009
Submission Type Official
Initial Submission Date 9/27/2019
Approval Date 10/29/2019
Effective Date 7/1/2019
Superseded SPA ID MD-18-0008
System-Derived

Payment Methodology

The State's Health Homes payment methodology will contain the following features

☐ Fee for Service

☐ Individual Rates Per Service

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

Describe below

Health Homes may receive a one-time reimbursement for the completion of each participants' initial intake and assessment necessary for enrollment into the Health Home. The payment will be the same as the rate paid for monthly services on a per-member basis.
The monthly rate is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland, including the provision of a minimum of two services in the month. The Health Homes are not paying any monies to other providers. There is only one exchange of payment and that is from the State to the Health Home providers.
Health Home providers must document services and outcomes within the participant's file and in eMedicaid. These documents are accessible to the Department and the Department's designees through eMedicaid and are auditable.
Rates are reviewed annually.
Health Home participants may only be enrolled in one Health Home at a time. If participant is enrolled in a Health Home, Maryland's system automatically blocks the participant from being enrolled in another Health Home.

Health Homes will be paid a monthly rate based on the employment costs of required Health Home staff, using salary and additional employment cost estimates for each of the required positions and their respective ratios. Payment is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland. Failure to meet such requirements is ground for payment sanctions or revocation of Health Home status.
The Department does not pay for separate billing for services which are included as part of another service. At the end of each month, Health Homes will ensure that all Health Home services and outcomes have been reported into eMedicaid. The provider will then submit a bill within 30 days for all participants that received the minimum Health Home service requirement in the preceding month.
The provider may begin billing for a Health Home participant when the intake portion of that individual's eMedicaid file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The initial intake process itself qualifies as a Health Home service. The ongoing criteria for receiving a monthly payment is:
1. The individual is identified in the State's Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;
2. The individual was enrolled as a Health Home member with the Health Home provider in the month for which the provider is submitting a

bill for Health Home services; and
3. The individual has received a minimum of two Health Home services in the previous month, which are documented in the eMedicaid system.
The agency's fee schedule (rate) was last updated on July 1, 2019 and is effective for services provided on or after that date. Effective July 1, 2019, the Health Home rate will be $110.19.

☐ Per Member, Per Month Rates

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

There are no variations in payment.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2019MS0002O | MD-19-0009 | Migrated_HH.MD HHS

Package Header

Package ID MD2019MS0002O

SPA ID MD-19-0009

Submission Type Official

Initial Submission Date 9/27/2019

Approval Date 10/29/2019

Effective Date 7/1/2019

Superseded SPA ID MD-18-0008

System-Derived

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

7/1/2019

Website where rates are displayed

health.maryland.gov/providerinfo

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2019MS0002O | MD-19-0009 | Migrated_HH.MD HHS

Package Header

Package ID	MD2019MS0002O	**SPA ID**	MD-19-0009
Submission Type	Official	**Initial Submission Date**	9/27/2019
Approval Date	10/29/2019	**Effective Date**	7/1/2019
Superseded SPA ID	MD-18-0008 System-Derived		

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Behavioral Health rates are typically reviewed and updated for inflation annually. This program was added to that annual review process in FY 2017.
Effective July 1, 2016 the Health Home rate will be increased 2% bringing the rate to $100.85. This change is being submitted to CMS through a separate process, with public notice being published June 10th. MD then increased the rateby 2%, effective July 1, 2017 and by 3.5% in 2018 and 2019. There is no tiered payment for this service. All Health Homes receive the same monthly rate if they perform the minimum number of services for that individual.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2019MS0002O | MD-19-0009 | Migrated_HH.MD HHS

Package Header

Package ID	MD2019MS0002O	**SPA ID**	MD-19-0009
Submission Type	Official	**Initial Submission Date**	9/27/2019
Approval Date	10/29/2019	**Effective Date**	7/1/2019
Superseded SPA ID	MD-18-0008		
	System-Derived		

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID MD2020MS0002O

SPA ID MD-20-0002

Submission Type Official

Initial Submission Date 3/31/2020

Approval Date 6/5/2020

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID MD-20-0002

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Optional Eligibility Groups	2/1/2020	MD-19-0004
Individuals Eligible for Family Planning Services	2/1/2020	MD-18-0005

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID MD2020MS0002O

SPA ID MD-20-0002

Submission Type Official

Initial Submission Date 3/31/2020

Approval Date 6/5/2020

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives To reflect integration into single streamlined application we need to update the RU for Family Planning to apply the MAGI household rules and income rules to FP applicants.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2020	$0
Second	2021	$0

Federal Statute / Regulation Citation

42 CFR 435.603, 42 CFR 435.214

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID MD2020MS0002O

SPA ID MD-20-0002

Submission Type Official

Initial Submission Date 3/31/2020

Approval Date 6/5/2020

Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Dennis Schrader
Medicaid Director
Maryland Department of Health
201 W. Preston St
Baltimore, MD 21201

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID	MD2020MS0002O	**SPA ID**	MD-20-0002
Submission Type	Official	**Initial Submission Date**	3/31/2020
Approval Date	6/5/2020	**Effective Date**	N/A
Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- (•) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- ( ) Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID MD2020MS0002O

SPA ID MD-20-0002

Submission Type Official

Initial Submission Date 3/31/2020

Approval Date 6/5/2020

Effective Date N/A

Superseded SPA ID N/A

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- ( ) Yes
- (•) No

Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations: This is a technical change previously announced in SPA ID MD-18-0005, for which Maryland obtained UIO approval.

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID MD2020MS0002O
SPA ID MD-20-0002
Submission Type Official
Initial Submission Date 3/31/2020
Approval Date 6/5/2020
Effective Date 2/1/2020
Superseded SPA ID MD-19-0004
System-Derived

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	○	NEW
Reasonable Classifications of Individuals under Age 21		☐	☐	○	CONVERTED
Children with Non-IV-E Adoption Assistance		☐	☐	○	CONVERTED
Independent Foster Care Adolescents		☐	☐	○	CONVERTED
Optional Targeted Low Income Children		☐	☐	○	CONVERTED
Individuals above 133% FPL under Age 65		☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		☐	☐	○	NEW
Individuals Eligible for Family Planning Services		☐	☐	○	APPROVED
Individuals with Tuberculosis		☐	☐	○	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for Cash Except for Institutionalization					NEW
Individuals Receiving Home and Community- Based Waiver Services under Institutional Rules					NEW
Optional State Supplement Beneficiaries					NEW
Individuals in Institutions Eligible under a Special Income Level					NEW
PACE Participants					NEW
Individuals Receiving Hospice					NEW
Children under Age 19 with a Disability					NEW
Age and Disability-Related Poverty Level					NEW
Work Incentives					NEW
Ticket to Work Basic					NEW
Ticket to Work Medical Improvements					NEW
Family Opportunity Act Children with a Disability					NEW
Individuals Receiving State Plan Home and Community-Based Services					APPROVED
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers					NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID MD2020MS0002O
SPA ID MD-20-0002
Submission Type Official
Initial Submission Date 3/31/2020
Approval Date 6/5/2020
Effective Date 2/1/2020
Superseded SPA ID MD-19-0004
System-Derived

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		☐	☐	○	NEW
Medically Needy Children under Age 18		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Protected Medically Needy Individuals Who Were Eligible in 1973		☐	☐	○	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Populations Based on Age, Blindness or Disability		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID	MD2020MS0002O	**SPA ID**	MD-20-0002
Submission Type	Official	**Initial Submission Date**	3/31/2020
Approval Date	6/5/2020	**Effective Date**	2/1/2020
Superseded SPA ID	MD-19-0004		
	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for Family Planning Services

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Individuals, regardless of gender, who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services.

Package Header

Package ID	MD2020MS0002O	**SPA ID**	MD-20-0002
Submission Type	Official	**Initial Submission Date**	3/31/2020
Approval Date	6/5/2020	**Effective Date**	2/1/2020
Superseded SPA ID	MD-18-0005		
	System-Derived		

The state covers the family planning eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are not pregnant

2. Are not otherwise eligible for and enrolled in mandatory coverage under the state plan

3. Are not otherwise eligible for and enrolled in optional full Medicaid coverage under the state plan

4. Have household income that does not exceed the income standard established by the state for this group

Individuals Eligible for Family Planning Services

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID	MD2020MS0002O	**SPA ID**	MD-20-0002
Submission Type	Official	**Initial Submission Date**	3/31/2020
Approval Date	6/5/2020	**Effective Date**	2/1/2020
Superseded SPA ID	MD-18-0005		
	System-Derived		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- (•) Yes
- ( ) No

Individuals Eligible for Family Planning Services

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID	MD2020MS0002O	**SPA ID**	MD-20-0002
Submission Type	Official	**Initial Submission Date**	3/31/2020
Approval Date	6/5/2020	**Effective Date**	2/1/2020
Superseded SPA ID	MD-18-0005 System-Derived		

C. Income Standard Used

1. The state uses the same income standard for all individuals covered.

- (•) Yes
- ( ) No

2. The income standard for this eligibility group is:

259.00% FPL

Individuals Eligible for Family Planning Services

Package Header

Package ID	MD2020MS0002O	**SPA ID**	MD-20-0002
Submission Type	Official	**Initial Submission Date**	3/31/2020
Approval Date	6/5/2020	**Effective Date**	2/1/2020
Superseded SPA ID	MD-18-0005		
	System-Derived		

D. Financial Methodologies

1. MAGI-based methodologies are used in calculating household income. Except as described in this section, for information on the methodology used for this group, please refer as necessary to MAGI-Based Methodologies, completed by the state.

2. The state uses the same financial methodology for all individuals covered.

- (•) Yes
- ( ) No

3. In determining eligibility for this group, the state includes the following household members:

- (•) a. All household members
- ( ) b. Only the individual

4. In determining eligibility for this group, the state increases the family size by one, counting the individual as two

- ( ) Yes
- (•) No

5. In determining eligibility for this group, the state counts the income of:

- (•) a. All household members
- ( ) b. Only the individual

Individuals Eligible for Family Planning Services

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0002O | MD-20-0002

Package Header

Package ID	MD2020MS0002O	**SPA ID**	MD-20-0002
Submission Type	Official	**Initial Submission Date**	3/31/2020
Approval Date	6/5/2020	**Effective Date**	2/1/2020
Superseded SPA ID	MD-18-0005		
	System-Derived		

E. Basis for Income Standard - Maximum Income Standard

☐ 1. The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

2. The state's maximum income standard for this eligibility group is the highest of the following:

- ◉ a. The state's current effective income level for the Pregnant Women eligibility group (42 CFR 435.116) under the Medicaid state plan.
- ○ b. The state's current effective income level for pregnant women under a Medicaid 1115 Demonstration.
- ○ c. The state's current effective income level for Targeted Low-Income Pregnant Women under the CHIP state plan.
- ○ d. The state's current effective income level for pregnant women under a CHIP 1115 Demonstration.

3. The amount of the maximum income standard is:

259.00% FPL

F. Family Planning Benefits

Benefits for this eligibility group are limited to family planning and related services described in the Benefit and Payments section of the state plan.

G. Additional Information (optional)

n/a

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 6/5/2020 5:05 PM EDT

MD - Submission Package - MD2020MS0004O - (MD-20-0006) - Health Homes

CMS-10434 OMB 0938-1188

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th St. Room 355
Kansas City, MO 64106

Center for Medicaid & CHIP Services

November 03, 2020

Mr. Dennis Schrader
Medicaid Director
Maryland Department of Health, Office of Health Care Financing
201 West Preston Street
Baltimore, MD 21201

Re: Approval of State Plan Amendment MD-20-0006 Migrated_HH.MD HHS

Dear Mr. Dennis Schrader:

On August 21, 2020, the Centers for Medicare and Medicaid Services (CMS) received Maryland State Plan Amendment (SPA) MD-20-0006 for Migrated_HH.MD HHS to increase the rates for the Behavioral Health, Health Home program, by 4 percent, for dates of service beginning July 1, 2020..

We approve Maryland State Plan Amendment (SPA) MD-20-0006 on November 03, 2020 with an effective date(s) of July 01, 2020.

Name	Date Created	
No items available		

If you have any questions regarding this amendment, please contact Talbatha Myatt at talbatha.myatt@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott
Director, Division of Program Operations
Center for Medicaid & CHIP Services

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID MD2020MS0004O
SPA ID MD-20-0006
Submission Type Official
Initial Submission Date 8/21/2020
Approval Date 11/3/2020
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Maryland
Medicaid Agency Name: Maryland Department of Health, Office

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID MD2020MS0004O

SPA ID MD-20-0006

Submission Type Official

Initial Submission Date 8/21/2020

Approval Date 11/3/2020

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID MD-20-0006

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Payment Methodologies	7/1/2020	MD-19-0009

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID MD2020MS0004O

SPA ID MD-20-0006

Submission Type Official

Initial Submission Date 8/21/2020

Approval Date 11/3/2020

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives In accordance with Governor Hogan's rate increase for Maryland Medical Assistance, this proposal would increase the rates for the Behavioral Health, Health Home program, by 4 percent, for dates of service beginning July 1, 2020.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2020	$36853
Second	2021	$110560

Federal Statute / Regulation Citation

N/A

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID MD2020MS0004O

SPA ID MD-20-0006

Submission Type Official

Initial Submission Date 8/21/2020

Approval Date 11/3/2020

Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Dennis Schrader
Medicaid Director
Maryland Department of Health

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID	MD2020MS0004O	**SPA ID**	MD-20-0006
Submission Type	Official	**Initial Submission Date**	8/21/2020
Approval Date	11/3/2020	**Effective Date**	N/A
Superseded SPA ID	N/A		

Name of Health Homes Program

Migrated_HH.MD HHS

☐ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
BPW MEDICAID PROVIDER RATE CHANGES FROM 7_1_2020 (1) (2)	8/20/2020 5:01 PM EDT	

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID MD2020MS0004O

SPA ID MD-20-0006

Submission Type Official

Initial Submission Date 8/21/2020

Approval Date 11/3/2020

Effective Date N/A

Superseded SPA ID N/A

Name of Health Homes Program:

Migrated_HH.MD HHS

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (•) Yes
- ( ) No

[ ] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

[ ] All Indian Health Programs

[ ] All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
8/4/2020	Email

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

[ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
UIO Approval-MD SPA 20-0006 Health Home Rate Increase	8/20/2020 2:02 PM EDT	

Indicate the key issues raised (optional)

[ ] Access

[ ] Quality

[ ] Cost

[ ] Payment methodology

[ ] Eligibility

[ ] Benefits

[ ] Service delivery

[ ] Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID MD2020MS0004O

SPA ID MD-20-0006

Submission Type Official

Initial Submission Date 8/21/2020

Approval Date 11/3/2020

Effective Date N/A

Superseded SPA ID N/A

SAMHSA Consultation

Name of Health Homes Program

Migrated_HH.MD HHS

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
8/4/2020

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID	MD2020MS0004O	**SPA ID**	MD-20-0006
Submission Type	Official	**Initial Submission Date**	8/21/2020
Approval Date	11/3/2020	**Effective Date**	7/1/2020
Superseded SPA ID	MD-19-0009		
	System-Derived		

Payment Methodology

The State's Health Homes payment methodology will contain the following features

☐ Fee for Service

☐ Individual Rates Per Service

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

Describe below

Health Homes may receive a one-time reimbursement for the completion of each participants' initial intake and assessment necessary for enrollment into the Health Home. The payment will be the same as the rate paid for monthly services on a per-member basis.
The monthly rate is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland, including the provision of a minimum of two services in the month. The Health Homes are not paying any monies to other providers. There is only one exchange of payment and that is from the State to the Health Home providers.
Health Home providers must document services and outcomes within the participant's file and in eMedicaid. These documents are accessible to the Department and the Department's designees through eMedicaid and are auditable.
Rates are reviewed annually.
Health Home participants may only be enrolled in one Health Home at a time. If participant is enrolled in a Health Home, Maryland's system automatically blocks the participant from being enrolled in another Health Home.

Health Homes will be paid a monthly rate based on the employment costs of required Health Home staff, using salary and additional employment cost estimates for each of the required positions and their respective ratios. Payment is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland. Failure to meet such requirements is ground for payment sanctions or revocation of Health Home status.
The Department does not pay for

separate billing for services which are included as part of another service. At the end of each month, Health Homes will ensure that all Health Home services and outcomes have been reported into eMedicaid. The provider will then submit a bill within 30 days for all participants that received the minimum Health Home service requirement in the preceding month. The provider may begin billing for a Health Home participant when the intake portion of that individual's eMedicaid file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The initial intake process itself qualifies as a Health Home service. The ongoing criteria for receiving a monthly payment is:
1. The individual is identified in the State's Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;
2. The individual was enrolled as a Health Home member with the Health Home provider in the month for which the provider is submitting a bill for Health Home services; and
3. The individual has received a minimum of two Health Home services in the previous month, which are documented in the eMedicaid system.
The agency's fee schedule (rate) was last updated on July 1, 2020 and is effective for services provided on or after that date. Effective July 1, 2020, the Health Home rate will be $114.60.

☐ Per Member, Per Month Rates

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

There are no variations in payment.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID MD2020MS0004O

SPA ID MD-20-0006

Submission Type Official

Initial Submission Date 8/21/2020

Approval Date 11/3/2020

Effective Date 7/1/2020

Superseded SPA ID MD-19-0009

System-Derived

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

7/1/2020

Website where rates are displayed

health.maryland.gov/providerinfo

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID	MD2020MS0004O	**SPA ID**	MD-20-0006
Submission Type	Official	**Initial Submission Date**	8/21/2020
Approval Date	11/3/2020	**Effective Date**	7/1/2020
Superseded SPA ID	MD-19-0009		
	System-Derived		

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Behavioral Health rates are typically reviewed and updated for inflation annually. This program was added to that annual review process in FY 2017.
Effective July 1, 2020 the Health Home rate will be increased 4% bringing the rate to $114.60 as a result of Maryland Senate Bill 190.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2020MS0004O | MD-20-0006 | Migrated_HH.MD HHS

Package Header

Package ID MD2020MS0004O

SPA ID MD-20-0006

Submission Type Official

Initial Submission Date 8/21/2020

Approval Date 11/3/2020

Effective Date 7/1/2020

Superseded SPA ID MD-19-0009

System-Derived

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 11/23/2020 12:56 PM EST

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

Package ID MD2020MS0003O
SPA ID MD-20-0013
Submission Type Official
Initial Submission Date 12/21/2020
Approval Date 5/21/2021
Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID MD-20-0013

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Presumptive Eligibility	1/1/2021	New
Individuals Eligible for Family Planning Services - Presumptive Eligibility	1/1/2021	New

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

Package ID MD2020MS0003O
SPA ID MD-20-0013
Submission Type Official
Initial Submission Date 12/21/2020
Approval Date 5/21/2021
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives The purpose of this amendment is to create a Family Planning Presumptive Eligibility (FPE) Program to enroll participants in a temporary eligibility group to receive family planning services. Participants enroll at Family Planning Qualified Entities (FPEQEs), which are Maryland Family Planning Program Delegate Service Sites enrolled in Medicaid that are in good standing. The goal of FPE is to provide a pathway to longer-term Family Planning Program coverage by allowing participants to have timely access to family planning health care services through an on-site, temporary eligibility determination.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	$970000
Second	2022	$1300000

Federal Statute / Regulation Citation

42 CFR 435.1103(c)

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
FPE SPA Cover Letter FINAL_signed	12/18/2020 3:49 PM EST	

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

Package ID MD2020MS0003O
SPA ID MD-20-0013
Submission Type Official
Initial Submission Date 12/21/2020
Approval Date 5/21/2021
Effective Date N/A
Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Dennis Schrader
Medicaid Director
Maryland Department of Health

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

Package ID MD2020MS0003O
SPA ID MD-20-0013
Submission Type Official
Initial Submission Date 12/21/2020
Approval Date 5/21/2021
Effective Date N/A
Superseded SPA ID N/A

Indicate whether public comment was solicited with respect to this submission.

- ( ) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- (•) Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- [ ] Newspaper Announcement
- [ ] Publication in state's administrative record, in accordance with the administrative procedures requirements
- [ ] Email to Electronic Mailing List or Similar Mechanism
- [ ] Website Notice
- [ ] Public Hearing or Meeting
- [ ] Other method

Upload copies of public notices and other documents used

Name	Date Created	
Printed Public Notice FPE	11/20/2020 3:20 PM EST	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
No items available		

Indicate the key issues raised during the public comment period (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

Package ID MD2020MS0003O
SPA ID MD-20-0013
Submission Type Official
Initial Submission Date 12/21/2020
Approval Date 5/21/2021
Effective Date N/A
Superseded SPA ID N/A

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

(•) Yes
( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

(•) Yes
( ) No

[ ] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

[ ] All Indian Health Programs
[ ] All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
11/23/2020	Email

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

[ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
UIO Approval - MD 20-0013 Family Planning Presumptive Eligibility (FPE) Program	12/17/2020 5:53 PM EST	PDF

Indicate the key issues raised (optional)

[ ] Access
[ ] Quality
[ ] Cost
[ ] Payment methodology
[ ] Eligibility

- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

Package ID MD2020MS0003O
SPA ID MD-20-0013
Submission Type Official
Initial Submission Date 12/21/2020
Approval Date 5/21/2021
Effective Date 1/1/2021
Superseded SPA ID New
User-Entered

The state provides Medicaid services to individuals during a presumptive eligibility period following a determination by a qualified entity.

Presumptive eligibility covered in the state plan includes:

Eligibility Groups

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility for Children under Age 19	☐	☐	○	NEW
Parents and Other Caretaker Relatives - Presumptive Eligibility	☐	☐	○	NEW
Presumptive Eligibility for Pregnant Women	☐	☐	○	CONVERTED
Adult Group - Presumptive Eligibility	☐	☐	○	CONVERTED
Individuals above 133% FPL under Age 65 - Presumptive Eligibility	☐	☐	○	NEW
Individuals Eligible for Family Planning Services - Presumptive Eligibility	☐	☐	○	APPROVED
Former Foster Care Children - Presumptive Eligibility	☐	☐	○	CONVERTED
Individuals Needing Treatment for Breast or Cervical Cancer - Presumptive Eligibility	☐	☐	○	NEW

Hospitals

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility by Hospitals	☐	☐	○	CONVERTED

Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

Package ID	MD2020MS0003O	**SPA ID**	MD-20-0013
Submission Type	Official	**Initial Submission Date**	12/21/2020
Approval Date	5/21/2021	**Effective Date**	1/1/2021
Superseded SPA ID	New User-Entered		

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Presumptive Eligibility

Individuals Eligible for Family Planning Services - Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

Package ID	MD2020MS0003O	**SPA ID**	MD-20-0013
Submission Type	Official	**Initial Submission Date**	12/21/2020
Approval Date	5/21/2021	**Effective Date**	1/1/2021
Superseded SPA ID	New		
	User-Entered		

The state covers family planning services for individuals qualifying for the family planning group under 42 CFR 435.214 when determined presumptively eligible by a qualified entity.

The state also covers medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting during the presumptive eligibility period.

- (•) Yes
- ( ) No

A. Presumptive Eligibility Period

1. The presumptive period begins on the date the determination is made.

2. The end date of the presumptive period is the earlier of:

   a. The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

   b. The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

3. Periods of presumptive eligibility are limited as follows:

   - ( ) a. No more than one period within a calendar year.
   - ( ) b. No more than one period within two calendar years.
   - ( ) c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.
   - (•) d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
   - ( ) e. Other reasonable limitation:

Individuals Eligible for Family Planning Services - Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

Package ID	MD2020MS0003O	**SPA ID**	MD-20-0013
Submission Type	Official	**Initial Submission Date**	12/21/2020
Approval Date	5/21/2021	**Effective Date**	1/1/2021
Superseded SPA ID	New		
	User-Entered		

B. Application for Presumptive Eligibility

☐ 1. The state uses a standardized screening process for determining presumptive eligibility.

☐ 2. The state uses the single streamlined paper and/or online application for Medicaid and Presumptive Eligibility, approved by CMS. A copy of the single streamlined paper and/or online application with questions necessary for a PE determination highlighted or denoted is attached.

☐ 3. The state uses a separate paper application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

☐ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Name	Date Created	
Family Planning Presumptive Eligibility screens - 03-12-2021	3/17/2021 4:27 PM EDT	

5. Describe the presumptive eligibility screening process:

Enrolled FPE workers will need to:

1. Check EVS to make sure the applicant is not already enrolled with Medicaid or the Medicaid Family Planning Program;
2. Complete an FPE application on behalf of the applicant using the Maryland Health Connection PE Portal consistent with the Department's policies, regulations, and training materials
3. Provide the applicant with a printed copy of the FPE denial or approval letter generated by the Maryland Health Connection PE Portal.
4. Provide the applicant with the following information:
a. If the applicant is approved, inform the applicant that a full Medical Assistance application must be completed by the last day of the month following the month in which the FPEQE makes the FPE determination in order to assess the applicant's eligibility for continued eligibility for Family Planning Program.
b. Discuss with the applicant how to apply for comprehensive Medical Assistance Program benefits and/or continued eligibility for the Family Planning Program using the information on the Approval or Denial Letters.

*There are some instances where remote applications are acceptable.
If an applicant is at the clinic and the clinic Worker is at another branch (ex. a different Planned Parenthood), the FPE Worker may engage with the applicant by phone or video connection to complete the application remotely. If the potential applicant is at home, the FPE Worker can call the applicant before their scheduled appointment to complete a FPE application. The FPEQE must have a way to provide the applicant with a copy of their eligibility determination letter.

C. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

1. The individual must meet the categorical requirements of 42 CFR 435.214.

2. Household income must not exceed the applicable income standard described at 42 CFR 435.214.

○ a. A reasonable estimate of MAGI-based income is used to determine household income.

◉ b. Gross income is used to determine household size.

☐ 3. State residency

☐ 4. Citizenship, status as a national, or satisfactory immigration status

Individuals Eligible for Family Planning Services - Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

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Superseded SPA ID	New		
	User-Entered		

D. Qualified Entities

1. The state uses entities, as defined in section 1920C, to determine eligibility presumptively for this eligibility group. These entities must be eligible to receive payment for services under the state's approved Medicaid state plan and determined by the state to be capable of determining presumptive eligibility for this group.

2. The following qualified entities are used to determine presumptive eligibility for this eligibility group.

☐ Other entity the agency determines is capable of making presumptive eligibility determinations

Name of entity	Description
Family Planning Qualified Entities (FPEQEs)	Family Planning Qualified Entities (FPEQEs), are Maryland Family Planning Program Delegate Service Sites enrolled in Medicaid that are in good standing.

☐ 3. The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved.

4. A copy of the training materials has been uploaded for review during the submission process.

Name	Date Created	
FPE Manual April 2021.final (1)	4/30/2021 10:32 AM EDT	
FPE Training April 2021.final (1)	4/30/2021 10:32 AM EDT	

Individuals Eligible for Family Planning Services - Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | MD2020MS0003O | MD-20-0013

Package Header

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Superseded SPA ID	New		
	User-Entered		

E. Additional Information (optional)

FPE: PERFORMANCE STANDARDS AND SANCTIONS
A. What are the performance standards?
The Department will monitor performance over time and will reach out to FPEQEs if issues arise. For example, the Department would reach out if very few people are being enrolled in full Medicaid or the majority of applicants that complete a full MA application are found ineligible for benefits on an ongoing basis.
B. What are the sanctions for failure to meet performance standards?
As the program progresses and the Department refines its standards and criteria, the Department will propose any enforcement of performance standards with a Plan of
1. How often one can be eligible for FPE coverage;
13
Correction (POC). The POC is meant to create a dialogue between the FPEQE and the Department in order to better uphold FPE policies and procedures.
If the FPEQE does not meet the prescribed standards within one calendar quarter, the Department will establish a written POC that describes:
1. Targets and timelines for improvements;
2. Steps to be taken in order to comply with the performance standards;
3. How additional staff training would be conducted, if needed;
4. The estimated time it would take to achieve the expected performance standards, which would be no greater than three months; and
5. How outcomes would be measured.
The Department may impose additional correction periods, as appropriate. If the FPEQE, or individual FPE Worker, does not meet targets after a sufficient period for improvement, as determined in POC discussions between the Department and the FPEQE, the Department may disqualify a FPEQE from participation as a FPE determination site.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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.

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Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2021MS0001O | MD-21-0005 | Migrated_HH.MD HHS

Package Header

Package ID MD2021MS0001O

Submission Type Official

Approval Date N/A

Superseded SPA ID MD-20-0006

System-Derived

Reviewable Unit Instructions

SPA ID MD-21-0005

Initial Submission Date 3/24/2021

Effective Date 1/1/2021

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

1/1/2021

Website where rates are displayed

health.maryland.gov/providerinfo

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2021MS0001O | MD-21-0005 | Migrated_HH.MD HHS

Package Header

Package ID	MD2021MS0001O	**SPA ID**	MD-21-0005
Submission Type	Official	**Initial Submission Date**	3/24/2021
Approval Date	N/A	**Effective Date**	1/1/2021
Superseded SPA ID	MD-20-0006		
	System-Derived		
Reviewable Unit Instructions			

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Behavioral Health rates are typically reviewed and updated for inflation annually. This program was added to that annual review process in FY 2017.
Effective January 1, 2021 the Health Home rate will be increased 3.5% bringing the rate to $118.61 as a result of Maryland Senate Bill 280 (2019).

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2021MS0001O | MD-21-0005 | Migrated_HH.MD HHS

Package Header

Package ID MD2021MS0001O

SPA ID MD-21-0005

Submission Type Official

Initial Submission Date 3/24/2021

Approval Date N/A

Effective Date 1/1/2021

Superseded SPA ID MD-20-0006

System-Derived

Reviewable Unit Instructions

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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.

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Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | MD2021MS0001O | MD-21-0005 | Migrated_HH.MD HHS

Package Header

Package ID MD2021MS0001O

SPA ID MD-21-0005

Submission Type Official

Initial Submission Date 3/24/2021

Approval Date N/A

Effective Date N/A

Superseded SPA ID N/A

Reviewable Unit Instructions

Name of Health Homes Program:

Migrated_HH.MD HHS

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (•) Yes
- ( ) No

☐ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

☐ All Indian Health Programs

☐ All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
3/16/2021	Email

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

☐ All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
UIO Approval - MD SPA 21-0005 BH Health Homes Rate Increase Jan 1, 2021	3/23/2021 3:44 PM EDT	

Indicate the key issues raised (optional)

☐ Access

☐ Quality

☐ Cost

☐ Payment methodology

☐ Eligibility

☐ Benefits

☐ Service delivery

☐ Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | MD2021MS0001O | MD-21-0005 | Migrated_HH.MD HHS

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Initial Submission Date 3/24/2021

Approval Date N/A

Effective Date N/A

Superseded SPA ID N/A

Reviewable Unit Instructions

SAMHSA Consultation

Name of Health Homes Program

Migrated_HH.MD HHS

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
8/4/2020

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2021MS0001O | MD-21-0005 | Migrated_HH.MD HHS

Package Header

Package ID MD2021MS0001O

SPA ID MD-21-0005

Submission Type Official

Initial Submission Date 3/24/2021

Approval Date N/A

Effective Date 1/1/2021

Superseded SPA ID MD-20-0006

System-Derived

Reviewable Unit Instructions

Payment Methodology

The State's Health Homes payment methodology will contain the following features

☐ Fee for Service

☐ Individual Rates Per Service

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

Describe below

Health Homes may receive a one-time reimbursement for the completion of each participants' initial intake and assessment necessary for enrollment into the Health Home. The payment will be the same as the rate paid for monthly services on a per-member basis.
The monthly rate is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland, including the provision of a minimum of two services in the month. The Health Homes are not paying any monies to other providers. There is only one exchange of payment and that is from the State to the Health Home providers.
Health Home providers must document services and outcomes within the participant's file and in eMedicaid. These documents are accessible to the Department and the Department's designees through eMedicaid and are auditable.
Rates are reviewed annually.
Health Home participants may only be enrolled in one Health Home at a time. If participant is enrolled in a Health Home, Maryland's system automatically blocks the participant from being enrolled in another Health Home.

Health Homes will be paid a monthly rate based on the employment costs of required Health Home staff, using salary and additional employment cost estimates for each of the required positions and their respective ratios. Payment is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland. Failure to meet such requirements is ground for payment sanctions or revocation of Health Home

status.
The Department does not pay for separate billing for services which are included as part of another service. At the end of each month, Health Homes will ensure that all Health Home services and outcomes have been reported into eMedicaid. The provider will then submit a bill within 30 days for all participants that received the minimum Health Home service requirement in the preceding month. The provider may begin billing for a Health Home participant when the intake portion of that individual's eMedicaid file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The initial intake process itself qualifies as a Health Home service. The ongoing criteria for receiving a monthly payment is:
1. The individual is identified in the State's Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;
2. The individual was enrolled as a Health Home member with the Health Home provider in the month for which the provider is submitting a bill for Health Home services; and
3. The individual has received a minimum of two Health Home services in the previous month, which are documented in the eMedicaid system.
The agency's fee schedule (rate) was last updated on January 1, 2021 and is effective for services provided on or after that date. Effective January 1, 2021, the Health Home rate will be $118.61.

☐ Per Member, Per Month Rates

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

There are no variations in payment.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2021MS0001O | MD-21-0005 | Migrated_HH.MD HHS

Package Header

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Reviewable Unit Instructions

SPA ID MD-21-0005

Initial Submission Date 3/24/2021

Effective Date 1/1/2021

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Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

1/1/2021

Website where rates are displayed

health.maryland.gov/providerinfo

Health Homes Payment Methodologies

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Superseded SPA ID	MD-20-0006		
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Reviewable Unit Instructions			

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

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2. Please identify the reimbursable unit(s) of service
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5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
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Health Homes Payment Methodologies

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Reviewable Unit Instructions

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

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☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

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MD - Submission Package - MD2022MS0003O - (MD-22-0017) - Health Homes

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2022MS0003O | MD-22-0017 | Migrated_HH.MD HHS

CMS-10434 OMB 0938-1188

Package Header

Package ID MD2022MS0003O
SPA ID MD-22-0017
Submission Type Official
Initial Submission Date 9/16/2022
Approval Date 11/18/2022
Effective Date 7/1/2022
Superseded SPA ID MD-21-0005
User-Entered

Payment Methodology

The State's Health Homes payment methodology will contain the following features

☐ Fee for Service

☐ Individual Rates Per Service

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

Describe below

Health Homes may receive a one-time reimbursement for the completion of each participants' initial intake and assessment necessary for enrollment into the Health Home. The payment will be the same as the rate paid for monthly services on a per-member basis.
The monthly rate is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland, including the provision of a minimum of two services in the month. The Health Homes are not paying any monies to other providers. There is only one exchange of payment and that is from the State to the Health Home providers.
Health Home providers must document services and outcomes within the participant's file and in eMedicaid. These documents are accessible to the Department and the Department's designees through eMedicaid and are auditable.
Rates are reviewed annually.
Health Home participants may only be enrolled in one Health Home at a time. If participant is enrolled in a Health Home, Maryland's system automatically blocks the participant from being enrolled in another Health Home.

Health Homes will be paid a monthly rate based on the employment costs of required Health Home staff, using salary and additional employment cost estimates for each of the required positions and their respective ratios. Payment is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland. Failure to meet such requirements is ground for payment sanctions or revocation of Health Home status.
The Department does not pay for separate billing for services which are included as part of another service. At the end of each month, Health Homes will ensure that all Health Home services and outcomes have been reported into eMedicaid. The provider will then submit a bill within 30 days for all participants that received the minimum Health Home service requirement in the preceding month. The provider may begin billing for a Health Home participant when the intake portion of that individual's eMedicaid file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The initial intake process itself qualifies as a Health Home service. The ongoing criteria for receiving a monthly payment is:
1. The individual is identified in the State's Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;
2. The individual was enrolled as a Health Home member with the Health Home provider in the month for which the provider is submitting a bill for Health Home services; and
3. The individual has received a minimum of two Health Home services in the previous month, which are documented in the eMedicaid system.
The agency's fee schedule (rate) was last updated on July 1, 2022 and is effective for services provided on or after that date. Effective July 1, 2022, the Health Home rate will be $127.21

☐ Per Member, Per Month Rates

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

There are no variations in payment.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2022MS0003O | MD-22-0017 | Migrated_HH.MD HHS

Package Header

Package ID MD2022MS0003O

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Approval Date 11/18/2022

Superseded SPA ID MD-21-0005

User-Entered

SPA ID MD-22-0017

Initial Submission Date 9/16/2022

Effective Date 7/1/2022

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

7/1/2022

Website where rates are displayed

https://health.maryland.gov/mmcp/Pages/Health-Homes.aspx

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2022MS0003O | MD-22-0017 | Migrated_HH.MD HHS

Package Header

Package ID	MD2022MS0003O	**SPA ID**	MD-22-0017
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5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Behavioral Health rates are typically reviewed and updated for inflation annually. This program was added to that annual review process in FY 2017.
Effective July 1, 2022 the Health Home rate will be increased 7.25% bringing the rate to $127.21 as a result of Maryland Senate Bill 290 (2022).

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MD2022MS0003O | MD-22-0017 | Migrated_HH.MD HHS

Package Header

Package ID	MD2022MS0003O	**SPA ID**	MD-22-0017
Submission Type	Official	**Initial Submission Date**	9/16/2022
Approval Date	11/18/2022	**Effective Date**	7/1/2022
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	User-Entered		

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
22-0017 Health Homes Rate Increase Standard Funding Questions	8/17/2022 10:27 AM EDT	

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MD - Submission Package - MD2023MS0003O - (MD-23-0005) - Eligibility

CMS-10434 OMB 0938-1188

Package Information

Package ID	MD2023MS0003O	**Submission Type**	Official
Program Name	N/A	**State**	MD
SPA ID	MD-23-0005	**Region**	Philadelphia, PA
Version Number	4	**Package Status**	Approved
Submitted By	Tyler Colomb	**Submission Date**	3/29/2023
Package Disposition		**Approval Date**	6/23/2023 12:56 PM EDT

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2023MS0003O | MD-23-0005

Package Header

Package ID	MD2023MS0003O	**SPA ID**	MD-23-0005
Submission Type	Official	**Initial Submission Date**	3/29/2023
Approval Date	06/23/2023	**Effective Date**	1/1/2023
Superseded SPA ID	MD-18-0005		
	User-Entered		

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19		☐	☐	○	CONVERTED
Parents and Other Caretaker Relatives		☐	☐	○	APPROVED
Pregnant Women		☐	☐	○	APPROVED
Deemed Newborns		☐	☐	○	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☐	☐	○	NEW
Former Foster Care Children		☐	☐	○	APPROVED
Transitional Medical Assistance		☐	☐	○	NEW
Extended Medicaid due to Spousal Support Collections		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
SSI Beneficiaries		☐	☐	○	NEW
Closed Eligibility Groups		☐	☐	○	NEW
Individuals Deemed To Be Receiving SSI		☐	☐	○	NEW
Working Individuals under 1619(b)		☐	☐	○	NEW
Qualified Medicare Beneficiaries		☐	☐	○	NEW
Qualified Disabled and Working Individuals		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Specified Low Income Medicare Beneficiaries					NEW
Qualifying Individuals					NEW

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | MD2023MS0003O | MD-23-0005

Package Header

Package ID MD2023MS0003O
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Initial Submission Date 3/29/2023
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B. The state elects the Adult Group, described at 42 CFR 435.119.

(•) Yes ( ) No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group		☐	☐	○	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | MD2023MS0003O | MD-23-0005

Individuals under the age of 26, who were in foster care and on Medicaid when they turned age 18 or aged out of foster care.

Package Header

Package ID	MD2023MS0003O	**SPA ID**	MD-23-0005
Submission Type	Official	**Initial Submission Date**	3/29/2023
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The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26

2. Were in foster care upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21).

3. Are described under either Section B. or C.

B. Individuals Covered

For individuals who turn 18 before January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration; and

b. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to B.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

☐ a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☐ b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☐ c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

C. Individuals Covered

For individuals who turn 18 on or after January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration; and

b. Are not enrolled in mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to C.1., the state elects to cover individuals who were in foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to a state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which that state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

☐ a. They were enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

☐ b. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

☐ c. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | MD2023MS0003O | MD-23-0005

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D. Additional Information (optional)

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