



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

August 29, 2008

Mr. John Colmers
Secretary
Maryland Department of Health & Mental Hygiene
201 W. Preston Street, Suite 500
Baltimore, MD 21201

Dear Mr. Colmers:

We are pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has reviewed and approved your request to renew the Maryland HealthChoice section 1115 Medicaid demonstration (No. 11-W-00099/3). This renewal is effective September 1, 2008, through June 30, 2011, upon which date, unless reauthorized, all waivers and authorities granted to operate this demonstration will expire. Approval of the project and its modification is granted under the authority of section 1115(a) of the Social Security Act.

Our approval of this renewal is subject to the limitations specified in the enclosed list of waivers and expenditure authorities. The State may deviate from the Medicaid State plan requirements to the extent those requirements have been specifically waived or, with respect to expenditure authorities, listed as inapplicable to expenditures for demonstration expansion populations and other services not covered under the Medicaid State plan.

The following programmatic changes are approved for the renewal as requested by the State. These include:

1. Primary Adult Care Program Benefit Incremental Increases - In Demonstration year 13, provider specialty and emergency room services will be added to program benefits. These services will include all specialty services provided in an office-based setting. In Demonstration year 14, outpatient hospital services will be added to the list of program benefits, including addictions treatment in outpatient hospital settings; and
2. Employed Individuals with Disabilities (EID) Program – Approval to sunset this program as the State will begin operating its EID program under the Medicaid State plan, rather than the demonstration, as of October 1, 2008. This program provides a Medicaid buy-in option for EIDs with incomes up to 300 percent of the Federal poverty level (FPL).

In addition, the State is required to comply with current CMS policy. Changes required due to policy compliance include:

1. Compliance with the CMS Crowd Out Policy - The State must continue to work with CMS regarding compliance with the assurances and requirements outlined in the August 17, 2007, State Health Official letter for new title XXI enrollees with income above 250 percent of the FPL for which the State seeks Federal financial participation.
2. Compliance with Family Planning Policy - To come into compliance with current family planning policy, the State is required to decrease the maximum income eligibility in its extended family planning program from 250 percent to 200 percent of the FPL. The State will effect that change by applying the new eligibility criteria at the time of the enrollee's annual redetermination, but no later than August 31, 2009.

At this time, CMS is not able to approve the State's request to adjust the per member per month (PMPM) rates used to create the budget neutrality without waiver expenditure limit due to the changes anticipated in the case mix of beneficiaries due to the Medicaid State Plan eligibility expansion that was effective July 1, 2008. Data sufficiency and stability issues along with time to collect appropriate data is needed. To address these issues, CMS has agreed to continue to collaborate with the State, to further design and complete the data and methods needed to adjust the PMPMs within Demonstration Year 12.

This approval is also conditioned upon acceptance and compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and the acceptance of the STCs, and waiver and expenditure authorities within 30 days of the date of this letter.

Your project officer is Ms. Diane Gerrits. She is available to answer any questions concerning your section 1115 demonstration. Ms. Gerrits' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: 410-786-8681
Facsimile: 410-786-5882
E-mail: Diane.Gerrits@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Gerrits and to Mr. Ted Gallagher, Associate Regional Administrator in our Philadelphia Regional Office. Mr. Gallagher's address is as follows:

Centers for Medicare & Medicaid Services
The Public Ledger Building
150 South Independence Mall West, Suite 216
Philadelphia, PA 19106

Page 3 – Mr. John Colmers

If you have questions regarding this correspondence, please contact Ms. Dianne E. Heffron, Acting Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at 410-786-5647. We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Kerry Weems
Acting Administrator

Enclosures

Page 4 – Mr. John Colmers

cc: Mr. Ted Gallagher
Associate Regional Administrator
Philadelphia Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00099/3
TITLE: HealthChoice Medicaid Section 1115 Demonstration
AWARDEE: Maryland Department of Health and Mental Hygiene

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning July 1, 2008, through June 30, 2011. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Maryland to carry out the HealthChoice Medicaid Section 1115 Demonstration.

- 1) Presumptive Eligibility Option** **Section 1902(a)(47) insofar as it incorporates sections 1920 and 1920A**

To permit the State to provide presumptive eligibility for pregnant women and children using a method for determining presumptive eligibility that differs from that required by statute.

- 2) Reasonable Promptness** **Section 1902(a)(8)**
Providing Medical Assistance **Section 1902(a)(10)(A)(ii)(XIV)**

To enable the State to delay the provision of medical assistance with reasonable promptness to optional targeted low income children, who are not infants under age 1 described in subsection 1902(a)(10)(A)(i)(IV), or children described in subsections 1902(a)(10)(A)(i)(VI) or 1902(a)(10)(A)(i)(VII), whose creditable health insurance coverage was voluntarily terminated during the 6-month period prior to an application for such assistance. The delay is in order for the State to impose a 6-month period of uninsurance before an optional targeted low-child is considered eligible for medical assistance if the child's private health insurance was voluntarily terminated in the 6 months prior to the child's application for assistance.

- 3) Amount, Duration, and Scope** **Section 1902(a)(10)(B)**

To enable the State to provide benefits specified in the STCs to enrollees participating in the Rare and Expensive Case Management program which are not available to other individuals under the Medicaid State plan.

4) Freedom of Choice

Section 1902(a)(23)

- a. To enable the State to restrict freedom of choice of provider for children with special needs, identified in section 1932(a)(2)(A)(i-v) of the Act who are enrolled in the demonstration.
- b. To enable the State to require that all Demonstration populations receive outpatient mental health services from providers enrolled with the public mental health system.

5) Retroactive Eligibility

Section 1902(a)(34)

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

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health and Mental Hygiene

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Maryland for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration extension, be regarded as expenditures under the State's title XIX plan.

The following expenditure authority shall enable Maryland to operate its section 1115 Medicaid HealthChoice Demonstration.

1. **Demonstration Population 13 [Primary Adult Care].** Expenditures on behalf of childless and non-custodial adults ages 19 and above, not otherwise eligible for Medicaid, Medicare or the State Children's Health Insurance Program, with incomes at or below 116 percent of the Federal poverty level (FPL) and resources not exceeding \$4,000 or \$6,000 for families of two or more, through December 31, 2008, after which the asset test will no longer be in effect, for the following services:
 - a. Primary, preventive, outpatient mental health, and pharmacy services only;
 - b. Beginning July 1, 2009, specialty care and emergency services in addition to those in subparagraph (a); and
 - c. Beginning July 1, 2010, outpatient hospital services in addition to those in subparagraphs (a) and (b).

2. **Demonstration Population 14 [Family Planning].**
 - a. Expenditures for family planning services for women of childbearing age with net incomes at or below 200 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period and do not have access to creditable health insurance. Continued program eligibility for these women will be determined once every 12 months by an active redetermination process for a maximum of 5 years.
 - b. Expenditures for family planning services delivered to women currently receiving such services whose incomes are between 200 and 250 percent of the FPL to the earlier of August 31, 2009, or the date upon which their continued eligibility for the program is determined using the new income criteria of 200 percent of the FPL.

3. **Demonstration Population 15 [Employed Individuals with Disabilities].**
 - a. Expenditures for health-care related services through September 30, 2008, for working individuals with disabilities whose income is at or below 300 percent of the FPL, and who, if not for income, would continue to be eligible under the Medicaid State plan.
 - b. Expenditures for health-care related services through September 30, 2008, for working individuals with disabilities whose income is at or below 300 percent of the FPL; who are receiving Supplemental Security Disability Insurance benefits; and who, if not for income, would continue to be eligible under the Medicaid State plan.
4. **Medicaid Eligibility Quality Control.** Expenditures that would have been disallowed as erroneous excess payments under section 1903(u) of the Act.
5. **Demonstration Benefits.** Expenditures for benefits specified in the STCs provided to enrollees participating in the Rare and Expensive Case Management program which are not available to individuals under the Medicaid State plan.
6. **Demonstration Operations.** Expenditures for capitation payments made to managed care organizations (MCOs) under a contract that does not require the MCO to:
 - a. Provide an enrollee with the disenrollment rights required by sections 1903(m)(2)(A)(vi) and 1932(a)(4) of the Act, when the enrollee is automatically re-enrolled into the enrollee's prior MCO after an eligibility lapse of no more than 120 days.
 - b. Enforce the requirement that an enrollee's verbal appeal be confirmed in writing as specified in sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 42 CFR 438.402(b)(3)(ii) and 42 CFR 438.406(b)(1).
 - c. Send a written notice of action for a denial of payment [as specified in 42 CFR 438.400(b)(3)] when the beneficiary has no liability, as required by sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 438.404(c)(2).

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Populations 13 and 14 beginning September 1, 2008, through June 30, 2011.

Title XIX Requirements Not Applicable to Demonstration Populations 13 and 14:

Amount, Duration, and Scope

Section 1902(a)(10)(B)

To enable the State to provide a limited benefit package to enrollees in a limited benefit program.

To enable the State to provide a benefit package consisting only of approved family planning services to women in Demonstration Population 14.

**Prospective Payment System for
Federally Qualified Health Centers and
Rural Health Clinics**

Section 1902(a)(15)

To enable the State to establish reimbursement levels to these clinics for a limited benefit package provided to PAC program participants, which is different from reimbursement levels established by the prospective payment system.

To enable the State to establish reimbursement levels to these clinics that would compensate them solely for family planning services rendered only to women enrolled in Demonstration Population 14.

Retroactive Eligibility

Section 1902(a)(34)

To exempt the State from extending eligibility prior to the date of application for Demonstration Populations 13 and 14.

**Early and Periodic Screening, Diagnostic,
and Treatment (EPSDT)**

Section 1902(a)(43)

To exempt the State from furnishing or arranging for EPSDT services for Demonstration Population 13 who are ages 19 or 20, and for Demonstration Population 14.

Title XIX Requirements Not Applicable to Demonstration Population 13 only:

Freedom of Choice

Section 1902(a)(23)

To enable the State to restrict freedom-of-choice of provider for enrollees in a limited benefit program.

Cost Sharing and Denial of Service

**Section 1902(a)(14) as it
would otherwise enforce 1916(e)**

To enable the State to allow pharmacy providers to deny service to enrollees for failure to pay the required cost sharing for pharmacy services.

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

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health and Mental Hygiene

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Maryland's HealthChoice section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Maryland Department of Health and Mental Hygiene (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective September 1, 2008, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration extension is approved through June 30, 2011.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility and Benefits; Cost Sharing; Delivery Systems; Family Planning Program; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration Extension Period. Additionally, three attachments have been included to provide supplemental information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The HealthChoice section 1115(a) Demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage and/or targeted benefits to certain individuals who would otherwise be without health insurance or without access to benefits tailored to the beneficiary's specific medical needs. The initial HealthChoice Demonstration was approved in 1996 to enroll most Medicaid recipients into managed care organizations (MCOs) beginning July 1, 1997.

The State's goal in implementing and continuing the Demonstration is to improve the health status of low-income Marylanders by:

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

- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care.

Under the statewide health care reform program, the State enrolls Demonstration eligibles into a managed care organization for comprehensive primary and acute care, and/or one of the Demonstration authorized health care programs. The targeted programs authorized solely by the Demonstration include the Rare and Expensive Case Management (REM) program, the Primary Adult Care (PAC) Program, the Employed Individuals with Disabilities (EID) program, and the postpartum Family Planning program. Mental health services are provided under the Demonstration in a separate fee-for-service delivery system. As of March 1, 2008, a total of 555,095 beneficiaries and Demonstration eligible individuals are enrolled in the HealthChoice program. This total includes 489,547 beneficiaries that are categorically eligible, as well as 30,128 PAC program participants, and 35,420 Family Planning program participants in expansion populations authorized by this Demonstration.

The HealthChoice program will evolve during this extension period by providing an eligibility expansion and a benefit expansion which were approved by the General Assembly in State fiscal year (SFY) 2008. The eligibility expansion will provide coverage through the Medicaid State plan to categorically eligible parent and caretaker adults with income above 30 percent of the Federal poverty level (FPL) to 116 percent of the FPL. As currently scheduled, the benefit expansion would provide additional benefits, on an incremental basis, under the limited benefit package available to PAC program participants. The ultimate goal of the PAC program benefit expansion initiative is to eventually provide participants similar benefits as compared to those available to Medicaid State plan eligible individuals.

In addition to these expansions, the State will begin operating its EID program under the Medicaid State plan, rather than the demonstration, as of October 1, 2008, and will reduce the Family Planning FPL limit from 250 percent of the FPL to 200 percent of the FPL at the time of eligibility redetermination in order to comply with current CMS policy directives beginning September 1, 2008.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and State Children's Health Insurance Program (SCHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and SCHIP programs expressed in law, regulation, court order, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part, must apply to the Demonstration.
3. **Changes in Medicaid and SCHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, court order, or policy directive, come into compliance with any changes in Federal law, regulation, court order, or policy affecting the Medicaid or SCHIP programs that occur during this Demonstration approval period, unless the provision being changed is explicitly waived under the STCs herein governing the Demonstration.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - a) To the extent that a change in Federal law, regulation, final court order, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.
 - b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day, such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or SCHIP State plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan is required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Demonstration provisions related to eligibility, enrollment, benefits, delivery systems, cost sharing, family planning services covered under this Demonstration, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below. The State will notify CMS of proposed Demonstration changes at the monthly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.
7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:
 - a) An explanation of the public process used by the State consistent with the requirements of paragraph 15 to reach a decision regarding the requested amendment;
 - b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
 - c) An up-to-date SCHIP Allotment Neutrality worksheet;

- d) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI State plan amendment; and
 - e) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.
8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. In addition, the State must submit to CMS a complete application at least 1 **year prior** to the expiration of the current section 1115(a) extension period. CMS will determine which authority is the most appropriate vehicle for granting an extension, if any. CMS will provide notice to the State of any outstanding items within 60 days of submission. Upon submission, the State will work with CMS to identify specific updates necessary to the submission based on significant programmatic changes (such as changes in State law, population demographics, or expenditures).
9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP must be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.
10. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.
11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS must promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.
13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or XXI. CMS must promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is

limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
15. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including, but not limited to, those referenced in paragraph 6 are proposed by the State.
16. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.
17. **Crowd-out strategies for higher income populations and maintaining focus on core populations.** The State must demonstrate the use of the same or similar crowd-out strategies as described below to ensure that public coverage under the SCHIP and Medicaid programs (and this Demonstration) does not substitute for private coverage. In addition, the State must submit a Demonstration amendment request in accordance with paragraph 7, if implementation of these strategies affects the administration or operation of the Demonstration. These strategies should apply to eligibility and coverage for new optional targeted low-income enrollees with family incomes above 250 percent of the FPL. Those crowd-out strategies should be of similar effectiveness as the strategies described in paragraph (a). In addition, the State should provide data described in paragraph (b). The requirements of this paragraph shall be changed where necessary to ensure consistency with any changes engendered by a court order or Federal law related to crowd-out strategies and related policies.
 - a) Effective crowd-out strategies are:
 - i. Cost sharing requirements under the State plan that, compared to private plans, are not more favorable to the public plan by more than 1 percentage point of the family income, unless the public plan's cost sharing is set at a 5 percent family cap;
 - ii. A minimum 1-year period of uninsurance for individuals who voluntarily terminate private insurance coverage prior to receiving coverage;
 - iii. Procedures to monitor and verify information regarding coverage provided by a noncustodial parent.
 - b) To ensure that the State fully serves the core population groups and effectively monitors the success of crowd-out measures, the State should provide data indicating:
 - i. Whether at least 95 percent of the children in the State below 200 percent of the FPL have health insurance coverage, including coverage through SCHIP or Medicaid;
 - ii. Whether the number of children in the target population insured through private employers has not decreased by more than 2 percentage points over the prior 5-year period; and
 - iii. Whether the State is current with all reporting requirements in SCHIP and reports on a monthly basis data relating to the crowd-out requirements.

IV. ELIGIBILITY AND BENEFITS

18. **Eligibility Overview.** Participation in HealthChoice is mandatory for the majority of Maryland's Medicaid eligible population. Medicaid, Medicaid Health Insurance Plan (MCHP) and MCHP Premium eligibles who participate in HealthChoice are enrolled in MCOs, or in the REM Program. In addition, certain individuals otherwise ineligible for Medicaid may be determined demonstration eligible for the PAC, EID, or the Family Planning program.
19. **Specific Eligibility Criteria.** The mandatory and optional Medicaid State plan populations listed below derive their eligibility through the Medicaid State plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the Demonstration to generate savings, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements. Groups which are made Demonstration-eligible by virtue of the expenditure authorities expressly granted in this Demonstration are subject to all applicable Medicaid laws or regulations in accordance with the Medicaid State plan, except as specified as not applicable in the expenditure authorities for this Demonstration.

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

Medicaid State Plan Mandatory Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Expenditure and CMS 64 Eligibility Group Reporting
TANF children, pregnant women, parents and caretaker adults, and foster care children	Families with dependent children with incomes less than 116 percent of the FPL. Includes individuals with incomes below the pre-July 1, 2008 TANF income thresholds.*	TANF Adults Thru 30, TANF Children Thru 30 or TANF Adults 31-116, TANF Children 31-116
SOBRA women and children	Children with incomes above the pre-July 1, 2008 TANF income threshold who are not enrolled in the TANF group: <ul style="list-style-type: none"> • Under age 1: Up to and including 185 percent of the FPL; • Ages 1 to 6: Up to and including 133 percent of the FPL; and • Ages 6 to 19: Up to and including 100 percent of the FPL; Pregnant women with incomes above the pre-July 1, 2008 standard* up to and including 250 percent of the FPL who are not enrolled in the TANF group.	SOBRA Adults or SOBRA Children
Non-Dual Blind and Disabled	Individuals whose Medicaid eligibility derives from their status as blind or disabled	SSI/BD Adults or SSI/BD Children

*The pre-July 1, 2008, TANF income standard is approximately 30% of FPL for a family of one. However, the FPL varies based on family size and could be as high as 40% of FPL. Because the income is linked to a dollar amount rather than FPL, the relative percent of the FPL will decrease annually.

Medicaid State Plan Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and CMS 64 Eligibility Group Reporting
Medically Needy adults and children	Individuals, whose income and resources exceed categorically needy limits, but meet Medicaid State plan standards.	MN Adults or MN Children
Optional targeted low income children through age 18	<ul style="list-style-type: none"> • Under age 1: between 185 and 200 percent of the FPL; • Ages 1 to 6: between 133 and 200 percent of the FPL; and • Ages 6 to 19: between 100 and 200 percent of the FPL 	MCHP (Only during periods when title XXI funding is exhausted)
The group of optional targeted low income children through age 18	Between 200 percent of the FPL and 300 percent of the FPL who pay a premium.	MCHP Premium (Only during periods when title XXI funding is exhausted)

Demonstration Eligible Groups	FPL and/or Other Qualifying Criteria	Expenditure and CMS 64 Eligibility Group Reporting
Family Planning Expansion	Women who lose Medicaid eligibility 60 days post partum up to 250 percent of the FPL through August 31, 2008 but up to and including 200 percent of the FPL beginning September 1, 2008, as described in paragraph 24.	Family Planning
PAC Program Participants	Childless and non-custodial adults up to and including 116 percent of the FPL with income and resources less than \$4000 or less than \$6000 for families of two or more through December 31, 2008. After January 1, 2009 there will be no asset or resource test.	PAC
EID Participants	Disabled working adults who have lost, or are at risk of losing, eligibility for SSI, SSDI or participation under section 1916 of the Act due to increased earned income up to 300 percent of the FPL. Individuals enrolled in this program will be transitioned to an excluded group no later than October 1, 2008.	Buy In

20. **Eligibility Exclusions.** The following persons will not participate in the HealthChoice Demonstration, and will receive benefits unaffected by the Demonstration.

Beneficiaries with dual Medicare/Medicaid coverage
Short term eligible beneficiaries in a spend-down status
Beneficiaries residing in long term care facilities
Beneficiaries enrolled in the Model Waiver Program
Beneficiaries enrolled in the Breast and Cervical Cancer Treatment Program (BCCTP)
Beneficiaries residing in skilled nursing facilities for more than 30 days
EID participants as of October 1, 2008

21. **HealthChoice Benefits.** The HealthChoice program provides comprehensive Medicaid State plan benefits to demonstration participants except for those as described below:

- a) PAC Benefits. Provides only office-based primary care and preventive services, pharmacy coverage and limited specialty mental health benefits to the population defined in this HealthChoice 1115 Demonstration expansion group. Specific benefits and the incremental increase of benefits in the limited benefit package are found in Attachment A.
- b) REM Program. The State offers to place individuals confirmed to have specified conditions that are expensive and require complex medical treatment in a special case management program. It is administered by the Maryland Department of Health and Mental Hygiene and includes certain non-Medicaid optional services to assist with the special needs of this population. Participants in this program are not enrolled in an MCO. Beneficiaries eligible for enrollment in REM derive their eligibility from the SCHIP or Medicaid State plan. Specific benefits provided to beneficiaries enrolled in the REM program are found in Attachment A.
- c) Family Planning Only Services. Family planning only services are provided to women who lose Medicaid eligibility after their pregnancy related eligibility for a period of 5 years from the date of eligibility unless the woman moves to another State or is enrolled in another eligibility category. These services are available as long as the woman remains a resident of Maryland and continues to meet eligibility requirements at the time of her active redetermination. Referral to primary care services is also part of this service, but the costs of the primary care services are not covered. The list of services for which the State may claim FFP under this program is contained in Attachment B.
- d) EID Program. Implemented in Demonstration Year (DY) 8, the EID provides Medicaid coverage for a limited number of employed individuals with disabilities who have lost, or risk losing, eligibility for SSI or participation under section 1916 of the Act due to increased earned income up to 300 percent of the Federal poverty level (FPL). This benefit under the demonstration will end no later than October 1, 2008, when this program will become authorized under the Medicaid State plan.

V. COST SHARING

22. The Medicaid eligible populations included in the demonstration may be charged co-payments and/or premiums as authorized by sections 1916 and 1916A of the Act and defined in the Medicaid State plan. Premiums and co-payments are charged as follows:

Population	Premiums	Co-Payments
HealthChoice Demonstration Eligibles	None	Except where prohibited by Federal law: <ul style="list-style-type: none"> • \$3.00 per prescription and refill for brand name drugs; and • \$1.00 per prescription and refill for generic drugs.
PAC Program Participants	None	<ul style="list-style-type: none"> • \$2.50 per prescription and refill for brand name drugs; and • \$7.50 per prescription and refill for generic drugs.
MCHP Premium Children through age 18 with incomes between 200 up to and including 250 percent of the FPL	\$46.00 per month*	None
MCHP Premium Children through age 18 with incomes between 250 percent of the FPL up to and including 300 percent of the FPL	\$58.00 per month*	None

* This amount is adjusted annually in March to reflect changes to the Federal poverty level.

VI. DELIVERY SYSTEMS

23. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the State with an MCO shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

VII. FAMILY PLANNING PROGRAM

24. Family planning services are provided to uninsured women who lose Medicaid eligibility at 60 days postpartum with family income at or below 200 percent of the FPL for a period of time up to 5 years providing the individual is redetermined eligible for the program on an annual basis. During the extension period, new participants will only be considered eligible if their income is no higher than 200 percent of the FPL. The State will have 12 months from the beginning of the extension period to disenroll current enrollees whose income exceeds 200 percent of the FPL at their annual eligibility redetermination.

- a) **Duplicate Payments.** The State must not use title XIX funds to pay for individuals enrolled in Medicare, Medicaid, SCHIP, any other Federally funded program (i.e., title X), or component of this section 1115 Demonstration who seek services under the family planning program. The State shall only enroll or reenroll individuals into the family planning program that are uninsured (defined as not having creditable coverage) and have incomes up to and including

200 percent of the FPL. During this 1-year period, the State shall pursue third party liability reimbursement for any currently enrolled individual who has other insurance and ensure that Medicaid will be the payer of last resort.

- b) **Primary Care Referral.** The State shall facilitate access to primary care services for enrollees in the family planning program. The State shall submit to CMS a copy of the written materials that are distributed to the family planning program participants as soon as available. The written materials must explain to the participants how they can access primary care services. In addition, the State must evaluate the impact of providing referrals for primary care services. This component of the evaluation must be highlighted in the evaluation design that will be submitted to CMS as specified in paragraph 59(b).
- c) **Eligibility Redeterminations.** The State will ensure that redeterminations of eligibility for this component of the Demonstration are conducted, at a minimum, once every 12 months.
 - i. **Process.** The process for eligibility redeterminations shall not be passive in nature, but will require that an action be taken by the family planning program recipient in order to continue eligibility for this program. The State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.
 - ii. **Integrity.** Within 60 days of approval of the demonstration renewal, the State will provide to CMS for approval, an appropriate methodology for ensuring the integrity of annual eligibility determinations of individuals covered under the family planning program. The State will use this methodology to conduct reviews of the eligibility determination process on an annual basis. As part of the submission, the State will also develop an eligibility determination error rate methodology. If annual reviews of the eligibility determination process suggest error rates beyond a State established threshold, the State will develop a corrective action plan for CMS approval.
 - iii. **Family Planning Program Income Limit.** Effective upon demonstration renewal, new participants will only be considered eligible if their income is no higher than 200 percent of the FPL. The State will have 12 months from the beginning of the extension period to disenroll current enrollees whose income exceeds 200 percent of the FPL at their annual eligibility redetermination. The State shall only enroll or reenroll individuals into the family planning program that are uninsured (defined as not having creditable coverage), not eligible for Medicaid, the PAC program, MCHP, MCHP Premium or Medicare, and have incomes up to and including 200 percent of the FPL.
 - iv. **Disenrollment.** A woman who loses family planning eligibility due to pregnancy, or no longer being able to bear children shall be disenrolled effective the first of the month following confirmation of the condition. A woman who is enrolled in another Medical Assistance eligibility category will be disenrolled at the end of the month prior to enrollment in another eligibility category for the subsequent month.

VIII. GENERAL REPORTING REQUIREMENTS

25. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section IX.

26. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.
27. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XI.
28. **Title XXI Reporting Requirements.** The State will provide CMS on a quarterly basis, an enrollment report for the title XXI populations showing end of quarter actual and unduplicated ever enrolled figures. This data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.
29. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.
30. **Quarterly Operational Reports.** The State must submit progress reports in the format specified in Attachment C no later than 60 days following the end of each quarter.

The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

- a) Updated budget neutrality and allotment neutrality monitoring spreadsheets;
 - b) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, including approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues;
 - c) Action plans for addressing any policy and administrative issues identified;
 - d) The number of individuals enrolled in the family planning program; and
 - e) Evaluation activities and interim findings.
31. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the

32. **Reporting Requirements Related to the Family Planning Program.**

- a) In each annual report required by paragraph 31, the State shall report the average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)
- b) In each annual report required by paragraph 31, the State shall report the number of actual births that occur to family planning demonstration participants. (Participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year.)
- c) The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates no later than October 1, 2008. For purposes of this section, “fertility rate” means birth rate. These rates must:
 - i. Reflect fertility rates during Base Year 1994 for women, age 15-44 years, with family incomes at or below 200 percent of the FPL and ineligible for Medicaid except for pregnancy; and
 - ii. Include births paid for by Medicaid.
- d) At the end of each DY, a DY fertility rate will be determined for Demonstration participants during that DY.

The base-year fertility rate and the DY fertility rate will be used to calculate a measure of births averted through the Demonstration using the following formula:

$$\text{Births Averted} = (\text{base-year fertility rate}) - (\text{fertility rate of Demonstration participants during DY}) \times (\text{number of Demonstration participants during DY})$$

The intent of the family planning program is to promote better birth outcomes for enrollees and avert unintended pregnancies for Demonstration participants.

IX. GENERAL FINANCIAL REQUIREMENTS

33. **Reporting Expenditures Under the Demonstration.** In order to track expenditures under this Demonstration, Maryland must report Demonstration expenditures through the Medicaid and SCHIP Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and section 2115 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments

were made). Expenditures for optional targeted low income children (MCHP and MCHP Premium children) claimed under the authority of title XXI shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS 64.21UP Waiver.

- a) For the family planning component of the Demonstration, the State should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:
 - i. Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage (FMAP) rate should be entered in Column (B) on the appropriate waiver sheets.
 - ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.
- b) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.
- c) For each Demonstration year, 15 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration populations and Demonstration services. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in bold following the colon. Expenditures should be allocated to these forms based on the guidance found below.
 - i. **Demonstration Population 1: TANF Adults Thru 30**—Eligibility Group (EG) consists of adults whose Medicaid eligibility derives from their status as a relative caring for a child, or a pregnant woman through 30 percent FPL.
 - ii. **Demonstration Population 2: TANF Children Thru 30**—EG consists of children whose Medicaid eligibility derives from their status as a minor child through 30 percent FPL.
 - iii. **Demonstration Population 3: TANF Adults 31-116**—EG consists of adults whose Medicaid eligibility derives from their status as a relative caring for a child, or a pregnant woman whose income is 31 percent through 116 percent FPL.
 - iv. **Demonstration Population 4: TANF Children 31-116**—EG consists of children whose Medicaid eligibility derives from their status as child whose income is 31 percent through 116 percent FPL.
 - v. **Demonstration Population 5: SSI/BD**—Adults EG consists of adults whose Medicaid eligibility derives from their status as blind or disabled.
 - vi. **Demonstration Population 6: SSI/BD**—Children EG consists of children whose Medicaid eligibility derives from their status as blind or disabled.

- vii. **Demonstration Population 7: Medically Needy Adults (MN Adults)**—EG consists of adults whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.
- viii. **Demonstration Population 8: Medically Needy Children (MN Children)**—EG consists of children whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.
- ix. **Demonstration Population 9: SOBRA Adult**—EG consists of income eligible pregnant women.
- x. **Demonstration Population 10: SOBRA Children**—EG consists of income eligible children born after September 30, 1983.
- xi. **Demonstration Population 11: MCHP**—EG consists of optional targeted low income children with incomes up to and including 200 percent of the FPL who do not pay premiums and who are eligible to claim title XIX funds under the State’s approved title XIX State plan only when the State has exhausted its title XXI allotment and only until the next title XXI allotment becomes available to the State.
- xii. **Demonstration Population 12: MCHP Premium**—EG consists of optional targeted low income children with incomes above 200 percent up to and including 300 percent of the FPL who pay premiums and who are eligible to claim title XIX funds under the State’s approved title XIX State plan only when the State has exhausted its title XXI allotment and only until the next title XXI allotment becomes available to the State.
- xiii. **Demonstration Population 13: PAC**—EG consists of childless and non-custodial adults up to and including 116 percent of the FPL with income and resources less than \$4,000 or less than \$6,000 for families of 2 or more. The resource test will no longer be applied as of December 31, 2008.
- xiv. **Demonstration Population 14: Family Planning**—EG consists of women who lose Medicaid eligibility 60 days post partum up to 250 percent of the FPL through August 31, 2008, but up to and including 200 percent of the FPL beginning September 1, 2008.
- xv. **Demonstration Population 15: Buy In**—EG consists of disabled working adults enrolled in the EID program who have lost, or are at risk of losing eligibility for SSI or SSDI participation under 1916 of the Act due to increased earned income up to 300 percent of the FPL. Individuals enrolled in this program will transition out of the demonstration as an eligibility exclusion no later than October 1, 2008

d) Specific Reporting Requirements for Demonstration Populations 11 and 12.

- i. The State is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI

must be reported on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver in accordance with the instructions in section 2115 of the State Medicaid Manual.

- ii. Title XIX funds are available under this Demonstration if the State exhausts its title XXI allotment once timely notification as described in subparagraph (iii) has been provided.
- iii. If the State exhausts its title XXI allotment prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for MCHP and MCHP Premium children. During the period when title XIX funds are used, expenditures related to this Demonstration Population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver. To initiate this:
 - 1) The State shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this Demonstration population; and
 - 2) The State shall submit:
 - a. An updated budget neutrality assessment that includes a data analysis which identifies the specific “with waiver” impact of the proposed change on the current budget neutrality expenditure cap. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change;
 - b. An up-to-date SCHIP allotment neutrality worksheet.

34. **Expenditures Subject to the Budget Agreement.** For purposes of this section, the term “expenditures subject to the budget neutrality agreement” must include all title XIX expenditures provided to individuals who are enrolled in this Demonstration as described in paragraph 33 (c)(i-xv). All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

35. **Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

36. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

37. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations:

- a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 30, the actual number of eligible member months for the Demonstration Populations defined in paragraph 33 (c)(i-xv). The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

- b) The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

38. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

39. **Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section X:

- a) Administrative costs, including those associated with the administration of the Demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and
- c) Net medical assistance expenditures authorized under section 1115 Demonstration for the HealthChoice program.

40. **Extent of FFP for the Family Planning Program.** CMS shall provide FFP for CMS-approved services (including prescriptions) provided to women under the family planning program at the following rates and as described in Attachment B.

- a) For procedures or services clearly provided or performed for the primary purpose of family planning (contraceptives and sterilizations) and which are provided in a family planning

setting, FFP will be available at the 90 percent Federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis that specifically identifies them as a family planning service.

- b) In order for family planning-related services to be reimbursed at the Federal Medical Assistance Percentage (FMAP) rate they must be defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a “family planning-related” problem was identified/diagnosed during a routine/periodic family planning visit. Services/surgery, which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital are not considered family planning-related services and are not covered under the Demonstration.
- c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for sexually transmitted infections as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. Subsequent treatment would be paid for at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.
- d) CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.
- e) Maryland will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding Systems (HCPCS) codes covered under the Demonstration on January 31 of each Demonstration year. The revised code list should reflect only changes due to updates in service codes for those services for which the State has already received approval.
- f) Changes to services listed in Attachment B will require an amendment to the Demonstration in accordance with Section III, paragraph 7.

41. **Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds shall not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

42. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

- a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.
- b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.
- d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

43. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

- 44. **Expenditures Subject to the Allotment Neutrality Limit.** Eligible title XXI Demonstration expenditures subject to the allotment neutrality agreement are expenditures for services provided through this Demonstration to title XXI children with FPL levels within the approved SCHIP State plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the State's available title XXI funding.
- 45. **Quarterly Expenditure Reporting through the MBES/CBES.** In order to track title XXI expenditures under this Demonstration, the State must report quarterly Demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual.

Title XXI expenditures must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for

reporting expenditures, the State is required to identify the program code and coverage (i.e., children).

46. **Claiming Period.** All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver.
47. **Standard Medicaid Funding Process.** The standard SCHIP funding process will be used during the Demonstration. The State must estimate matchable Medicaid expansion SCHIP (M-CHIP) expenditures on the quarterly Form CMS-37.12 (Narrative) for both Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). On the CMS-37.12, the State must separately identify estimates of expenditures for the Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 waiver forms with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
48. **Administrative Costs.** All administrative costs are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.
49. **State Certification of Funding Conditions.** The State will certify that State/local monies are used as matching funds for the Demonstration. The State further certifies that such funds must not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS must be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
50. **Limitation on Title XXI Funding.** Maryland will be subject to a limit on the amount of Federal title XXI funding that the State may receive for Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the Demonstration children until the next allotment becomes available.
51. **Exhaustion of Title XXI Funds.** After the State has exhausted title XXI funds, expenditures for optional targeted low income children within SCHIP State plan-approved income levels, may be claimed as title XIX expenditures as approved in the Medicaid State plan. The State shall report expenditures for these children, identified as MCHIP and MCHIP Premium, as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with Section VIII, paragraph 33(d)(i-iii).

52. **Exhaustion of Title XXI Funds Notification.** The State must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures. The State must follow Maryland Medicaid State plan criteria for the beneficiaries unless specific waiver and expenditure authorities are granted through this demonstration.

XI. MONITORING BUDGET NEUTRALITY

53. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

54. **Risk.** The State shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles. Because CMS provides FFP for all Demonstration eligibles, Maryland shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Maryland at risk for the per capita costs for current eligibles, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures had there been no Demonstration.

55. **Demonstration Populations Used to Calculate the Budget Neutrality Expenditure Limit.** The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration:

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each EG described as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 37 for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (ii) below.
 - ii. The PMPM costs reflected below for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration will be adjusted as described in subparagraph (vi) below, no later than June 30, 2009. The PMPM cost for each EG will be increased by the appropriate growth rate included in the 2009 President's Budget for DYs 12, 13, and 14, as outlined in the following table.

Eligibility Group	DY 12 - DY14 Growth Rate	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM
TANF Adults	6.95 percent	\$337.26	\$360.70	\$385.77
TANF Children	6.95 percent	\$337.26	\$360.70	\$385.77
SSI/BD Adults	6.86 percent	\$1392.36	\$1487.88	\$1589.95
SSI/BD Children	6.86 percent	\$1392.36	\$1487.88	\$1589.95
Medically Needy Adults	6.86 percent	\$1264.26	\$1350.99	\$1443.67
Medically Needy Children	6.86 percent	\$1264.26	\$1350.99	\$1443.67
SOBRA Adults	6.95 percent	\$567.70	\$607.16	\$649.36
SOBRA Children	6.95 percent	\$567.70	\$607.16	\$649.36
MCHP	N/A	N/A	N/A	N/A
MCHP Premium	N/A	N/A	N/A	N/A

- iii. The annual budget neutrality expenditure cap for the Demonstration is the sum of the annual EG estimate for each EG calculated in subparagraph ii above as well as, the *actual* expenditures for the MCHP and MCHP Premium EGs claimed as title XIX expenditures as approved in the Medicaid State plan when the State has exhausted title XXI funding.
- iv. The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality cap calculated in subparagraph iii, that includes the *actual* expenditures for the MCHP and MCHP Premium EGs claimed as title XIX expenditures as approved in the Medicaid State plan when the State has exhausted title XXI funding. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations described in subparagraphs (ii) and (iii) above during the Demonstration period reported.
- v. **Composite Federal Share Ratio.** The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable Demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for the family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed-upon method.
- vi. **Case Mix Adjustment in DY 12.** During DY 12 the State must collect and submit the appropriate data as described below no later than March 31, 2009. These data will be used to determine and adjust the PMPM amounts in the subparagraph (ii) chart above in order to more accurately reflect the PMPM amounts for each subgroup of the PMPM groups used prior to this renewal. Should the PMPM amounts be indeterminant because

of failure to deliver these data, or data insufficiency, the PMPM amounts indicated in the chart found in subparagraph (ii) above will not be adjusted.

- a. **DY10 Baseline Data.** The following data elements will be used to define the point in time case mix distribution for DY10.

Population Prior to State Plan Expansion	Enrollment - Total Ever in Year	Member Months	Total Expenditures
TANF Adult Males			
TANF Adult Females			
TANF Children			
SOBRA Adult Females			
SOBRA Children			
Non Disabled Medically Needy Adults			
Non Disabled Medically Needy Children			
Disabled Medically Needy Adults			
Disabled Medically Needy Children			
SSI/BD Adults			
SSI/BD Children			

- b. **DY 12 Experience Data.** The following data elements must be provided for the first 6 months of DY 12 for use in the case mix adjustment.

Population After State Plan Expansion	Enrollment - Total Ever in 6 months	Member Months
TANF Thru 30 Adult Males		
TANF Thru 30 Adult Females		
TANF Thru 30 Children		
TANF 31-116 Adult Males		
TANF 31-116 Adult Females		
TANF 31-116 Children		
SOBRA Adult Females		
SOBRA Children		
Non Disabled Medically Needy Adults		
Non Disabled Medically Needy Children		
Disabled Medically Needy Adults		
Disabled Medically Needy Children		
SSI/BD Adults		
SSI/BD Children		

- c. **Case Mix Adjustment Methodology.** The State and CMS will collaborate to ensure that a mutually satisfactory case mix adjustment methodology is developed using the data submitted in subparagraphs (a) and (b) above. In addition, completion factors for each EG for use in completing the 6 months of data submitted in subparagraph (b) will also be developed collaboratively to account for the categorical shifting of enrolled beneficiaries among EGs after July 1, 2008.

56. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

<u>Demonstration Year</u>	<u>Cumulative Expenditure Cap Definition</u>	<u>Percentage</u>
Year 12	Budget neutrality expenditure cap plus	1 percent
Years 12 and 13	Combined budget neutrality expenditure caps plus	0.5 percent
Years 13 through 14	Combined budget neutrality expenditure caps plus	0 percent

In addition, the State may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure limit indicates a possibility that the Demonstration will exceed the limit during this extension.

57. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period, the budget neutrality expenditure limit has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

58. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) and (b), the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding all programs in the Demonstration. The State must submit to CMS for approval a draft evaluation design no later than January 1, 2009. The evaluation must outline and address evaluation questions for both of the following components, including the specific measurements for the Family Planning program:

- a) **HealthChoice.** At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.
- b) **Family Planning Program.** The draft design must include a discussion of the goals,

objectives and evaluation questions specific to this component of the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the family planning program, particularly among the target family planning population, during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the family planning program shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology:

Measure	Number	Percentage Change
Enrollment		
Averted Births		
Family Planning Patients Receiving a Clinical Referral for Primary Care	(estimate may be based on a sample)	

59. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State’s request for each subsequent renewal.

60. **Final Evaluation Plan and Implementation.**

- a) CMS shall provide comments on the draft designs within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 59, within 60 days of receipt of CMS comments.
- b) The State must implement the evaluation designs and report its progress on each in the quarterly reports.
- c) The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

61. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration, the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS.

XIII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	Reference
October 1, 2008	Submit Process and Methodology for Eligibility Redeterminations for Family Planning Program	Section VII, paragraph 24
October 1, 2008	Submit Base-year Fertility Rates for Family Planning Program	Section VIII, paragraph 32
January 1, 2009	Submit Draft Evaluation Plan	Section XII, paragraph 58
March 31, 2009	Submit Case Mix Adjustment Data	Section XI, paragraph 55
July 1, 2010	Submit Interim Evaluation Report if Requesting Extension	Section XII, paragraph 59
July 1, 2010	Submit Demonstration Application for Extension if Requesting Extension	Section III, paragraph 8
June 30, 2011	Submit Final Evaluation Report, if Not Requesting Extension	Section XII, paragraph 60

	Deliverable	Reference
Annual	By January 31 – Updated Family Planning Code List	Section IX, paragraph 40
	By October 1 st - Draft Annual Report	Section VIII, paragraph 31
Each Quarter		
	Quarterly Operational Reports	Section VIII, paragraph 30
	Quarterly Enrollment Reports	Section VIII, paragraph 28
	CMS-64 Reports	Section IX, paragraph 33
	Eligible Member Months	Section IX, paragraph 37

ATTACHMENT A

Primary Adult Care (PAC) and Rare and Expensive Case Management (REM) Program Benefits

PAC Program Benefits

An MCO shall provide an enrollee the primary care services listed below:

- Primary and preventative services;
- Physician services (other than specialty services);
- Pharmacy (excluding specialty mental health drugs and HIV/AIDS drugs);
- Primary mental health;
- Lab:
 - Complete blood count;
 - Chemistry panel including lipid profile;
 - Urine dipstick;
 - Urinalysis
 - Urine culture and sensitivity studies
 - Family planning labs;
 - PAP smear;
 - PSA;
 - STIs
 - Fecal occult blood
 - Blood glucose and glucose tolerance testing;
 - Hemoglobin A1C; and
 - Therapeutic drug monitoring (excluding some HIV/AIDS related tests);
- Radiology:
 - EKG;
 - Mammogram;
 - Chest x-ray; and
 - X-ray for suspected fracture;
- Limited DME for diabetics:
 - Diabetic supplies;
 - Non custom Orthotics and footwear;
 - Glucose meters and related supplies; and
 - Insulin syringes;
- Nutrition education for diabetics;
- Podiatry for diabetics; and
- Vision care for diabetics.

PAC enrollees are able to access certain services through the fee-for-service program as well. Fee-for-service covered benefits include:

- Freestanding clinic and office-based limited specialty mental health services;
- Outpatient psychiatric rehabilitation services;
- Specialty mental health drugs;
- HIV/AIDS related drugs.

ATTACHMENT A

Primary Adult Care (PAC) and Rare and Expensive Case Management (REM) Program Benefits

PAC Program Benefits Scheduled to be Added July 1, 2009

- All medically necessary specialty services performed in office based settings.
- All medically necessary services performed in an Emergency Room setting.

PAC Program Benefits Scheduled to be Added July 1, 2010

- All medically necessary outpatient hospital services, including surgeries.

REM Program Benefits

The REM Program provides all medically necessary services to individuals with specific qualifying conditions. In addition to State Plan benefits, REM provides:

- Chiropractic services for over 21*
- Dental coverage for over 21*
- Nutritional counseling for over 21*
- Nutritional supplements
- Physician participation in development of a treatment plan
- Occupational therapy for over 21*
- Speech, Hearing and Language services for over 21*
- Shift nursing services for over 21*
- Certified nursing assistant for over 21*
- Home health aide for over 21*

*These services are covered under the EPSDT benefit for children.

ATTACHMENT B

Family Planning Code List

The following procedure codes are approved family planning services as noted below:

Procedure Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
99201-99205	Office Visits		X	
99211-99215	Office Visits		X	
99383-99386	Office Visits - preventive		X	
99393-99396	Office Visits - preventive		X	
T1015	Clinic Visit-FQHC		X	
36415	Venipuncture		X	
36416	Capill Blood		X	
36600	Venipuncture		X	
80061	Lipid Panel		X	
81000-812003	Urine analysis		X	
81005	Urine analysis		X	
81007	UA-Bacteria Scr		X	
81015	UA-		X	
81025	Pregnancy Test		X	
81099	Unlisted UA		X	
82465	Cholesterol, total		X	
82947-82948	Glucose, FBS, Quant and Strip		X	
82951-82952	GTT		X	
82962	Glucose, FBS		X	
83020	Hemoglobin Electrophor		X	
83718	HDL Chol		X	
83909	Mol-capil. Electrophor		X	
84156	Protein, urine		X	
84165	Protein electoph		X	
84478	Triglycerides		X	
84702-84703	GC		X	
84999	Unlisted Chemistry Proc		X	
85007	Blood Smear with Diff		X	
85013-85014	Blood Count		X	
85018	Blood Count- Hgb		X	
85025	Blood Count with Diff		X	
85027	Blood Count		X	
85041	Bood Count- RBC		X	
85048	Blood Count- WBC		X	
85999	Unlisted hemat proc		X	
86631	Chlamydia		X	
86592-86593	Syphilis Test		X	
86692	Hepatitis, antib		X	
86701-86703	HIV		X	
86704-86707	Hep. B antibodies		X	
86708-86709	Hep A antibodies		X	
86762	Rubella Antibody		X	
86803-86804	Hep. C Antibodies		X	

ATTACHMENT B

Family Planning Code List

Procedure Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
86999	Unlisted Immunol. Proc		X	
87186	Sensitiv. Antibiotic		X	
87070	Culture, Bacterial		X	
87081	Culture, Bacterial		X	
87110	Chlamydia		X	
87184	Sensitiv.		X	
87205	Smear with interpret.		X	
87210	Smear-wet mount		X	
87220	Smear-fungi		X	
87252	Virus Id Tissue		X	
87270	Chlamydia		X	
87273	Infectious Agent- Herpes		X	
87340-87341	Infectious Agent- Hep B		X	
87350	Hep B Antigen		X	
87380	Hepatitis, Delta Agent		X	
87449-87450	Infectious Agent- not specified		X	
87480	Candida		X	
87490-87491	Inf Agent- Chlamydia		X	
87510	Gardnerella		X	
87515-87517	Hep B Virus		X	
87520-87522	Hep C Virus		X	
87525-87527	Hep G Virus		X	
87590-87592	Gonorrhea		X	
87620-87622	HPV		X	
87660	Infect. Agent- Trich		X	
87797-87799	Infect. Agent		X	
87850	Neis. Gonorrhea		X	
87899	Infect. Agent- not specif.		X	
88112	Cytopath. Select cell enhanc.		X	
88141-88143	Cytopathology		X	
88147-88148	Cytopathology		X	
88150	Cytopathology		X	
88152-88154	Cytopathology		X	
88155	Cytopathology		X	
88164--88167	Cytopathology		X	
88174-88175	Cytopathology		X	
J1055	Depo	X		
J7300	IUD- Paragard	X		
J7302	Mirena	X		
58300	IUD Insertion	X		
58301	IUD Removal	X		
A4266	Diaphragm	X		
57170	Diaphragm Fitting	X		
A4261	Cervical Cap	X		

ATTACHMENT B

Family Planning Code List

Procedure Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
J7303	Hormonal Ring	X		
J7304	Hormonal Patch	X		
99070	Unlisted Contracep. Devices	X		
J7307	Implanon	X		
11976	Removal Norplant	X		
11981	Implanon Insertion	X		
11982	Implanon Removal	X		
11983	Implanon Removal and Reinser	X		
58565	Sterilization	X		
58600	Sterilization	X		
58611	Sterilization	X		
58615	Sterilization	X		
58670-58671	Sterilization	X		
58340	HSG- post Essure		X	
57420	Colposcopy/entire vagina			X
57421	Colposcopy with biopsy			X
57452	Colposcopy/cervix			X
57454	Colpo w biopsy/endocurettage			X
57455	Colpo w biopsy cervix			X
57456	Colpo w endocurettage			X
57460	Colpo w loop electrode biopsy			X
57461	Colpo w loop conization			X
57505	Endo Curettage			X
57510	Cautery of Cervix			X
57511	Cryocautery			X
8:12	Anitibacterials			X
	8:12.06 Cephalosporins			X
	8:12.07 Misc β -Lactams			X
	8:12.12 Macrolides			X
	8:12.16 Penicillins			X
	8:12.20 Sulfonamides			X
	8:12.24 Tetracyclines			X
8:14	Antifungals			X
8:36	Urinary Anit-infective			X

ATTACHMENT C

Quarterly Operational Report Format

Under Section VIII, paragraph 30, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration.

The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Maryland HealthChoice Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 12 (July 1, 2008, through June 30, 2009)

Federal Fiscal Quarter: 4/2008 (7/08 - 9/08)

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

Enrollment Counts

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)
TANF Adults Thru 30	
TANF Children Thru 30	
TANF Adults 31-116	
TANF Children 31-116	
SSI/BD Adults	
SSI/BD Children	
Medically Needy Adults	

ATTACHMENT C

Quarterly Operational Report Format

Medically Needy Children	
SOBRA Adults	
SOBRA Children	
MCHP	
MCHP Premium	
Family Planning	
PAC	
Buy-In	

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Family Planning Program

Identify all significant program developments/issues/problems that have occurred in the current quarter, including the required data and information under Section VII, including enrollment data requested that is not represented in the formatted tables.

REM Program

- Beneficiaries Enrolled
- Programmatic Update

PAC Program

- Enrollment Activities and/or Backlog
- Benefit Expansion Status

MCHP and MCHP Premium Status/Update/Projections

EID Program Transition

Expenditure Containment Initiatives

Identify all current activities, by program and or demonstration population. Include items such as status, and impact to date as well as short and long-term challenges, successes and goals.

Financial/Budget Neutrality Development/Issues

ATTACHMENT C

Quarterly Operational Report Format

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
TANF Adults Thru 30				
TANF Children Thru 30				
TANF Adults 31-116				
TANF Children 31-116				
SSI/BD Adults				
SSI/BD Children				
Medically Needy Adults				
Medically Needy Children				
SOBRA Adults				
SOBRA Children				
MCHP				
MCHP Premium				

B. For Informational Purposes Only

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Family Planning				
PAC				
Buy-In				

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Legislative Update

Discussion of health care initiatives, funding for PAC expansion status, or other pertinent pending legislation.

Quality Assurance/Monitoring Activity

ATTACHMENT C

Quarterly Operational Report Format

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS