

**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 authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Maryland to operate its section 1115 Medicaid HealthChoice demonstration.

The expenditure authorities listed below promote the objectives of title XIX in the following ways:

- Increases overall coverage of low-income individuals in the state and
- Improves health outcomes for Medicaid and other low-income populations in the state.

- 1. Demonstration Population 11 [Family Planning].** Expenditures for family planning and family planning related services for women, of childbearing age, who are not otherwise eligible for Medicaid, CHIP or Medicare, and who have income at or below 200 percent of the federal poverty level (FPL).
- 2. Demonstration Population 12 [Increased Community Services].** Expenditures for home and community-based services provided to individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the State plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the following conditions:
 - a. Individuals must meet one of the following criteria:
 - i. Is residing (and has resided for at least ninety (90) consecutive days) in a nursing facility and is receiving Medicaid benefits for nursing home services furnished by such nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the ninety (90) day nursing home stay requirement; or

- ii. Is currently receiving services through the Home and Community-Based Options waiver, and whose income exceeds the income eligibility threshold by no more than 5 percent. These individuals would be permitted to transition directly into the Increased Community Program (ICS) program as long as they continued to meet the nursing facility level-of-care standard. The ninety (90) day nursing home stay requirement does not apply to these individuals.
- b. Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act.
- c. The cost to Medicaid for the individual in the community must be less than the cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.
- d. Pursuant to STC 24, the state may not enroll more than 100 participants into the ICS program at any one time.

Allowable expenditures shall be limited to those consistent with statutory post eligibility and spousal impoverishment rules.

3. **Demonstration Population 13 [Women with Breast and Cervical Cancer].** Expenditures for women with breast and cervical cancer, with incomes above 133 percent and up to 250 percent of the FPL who were enrolled in the Breast and Cervical Cancer Treatment Act Program as of December 31, 2013.
4. **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. This includes the services provided to REM enrollees who remain in the REM program after becoming eligible for Medicare in order to allow them to continue to receive private duty nursing and shift home health aide services until age 65.
5. **Full Medicaid Benefits for Presumptively Eligible Pregnant Women.** As of January 1, 2014, expenditures to provide full Medicaid State plan benefits to presumptively eligible pregnant women with incomes up to 250 percent of the FPL.
6. **Demonstration Operations for Automatic Reenrollment into the MCO.** 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, along with 42 CFR 438.56(g), when the enrollee is automatically re-enrolled into the enrollee's prior MCO after an eligibility lapse of no more than 120 days. This expenditure authority does not impact the requirements under 42 CFR 438.56(c)(2)(iii). Section 438.56(c)(2)(iii) allows a beneficiary to request disenrollment if a temporary loss of eligibility caused the beneficiary to miss the annual disenrollment opportunity.

- 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). As of July 1, 2017, the regulations cite changes to 42 CFR 438.402(c)(3)(ii) and 42 CFR 438.406(b)(3). When a beneficiary’s oral request for an appeal is not followed up in writing, the plan will send written confirmation of the appeal request to the beneficiary or the beneficiary’s authorized representative.
- 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). The expenditure authority expires on December 31, 2017.

7. Residential Treatment for Individuals with Substance Use Disorder (SUD).

Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for SUD and withdrawal management during up to two non-consecutive stays of thirty (30) days or less annually in facilities that meet the definition of an institution for mental disease (IMD).

8. Dental Benefits for Former Foster Care Youth. Expenditures for additional dental benefits beyond those specified in the state plan for former foster care youth ages 21 up to (but not including) age 26.

9. Evidence Based Home Visiting Services Pilot. Expenditures for evidence-based home visiting services by licensed practitioners to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children up to age two (2).

10. Assistance in Community Integration Services Pilot. Expenditures for home and community-based services (HCBS) and related services as described in STC 28.

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 11, 12, and 13.

Title XIX Requirements Not Applicable to Demonstration Populations 11 (Family Planning) and 12 (Increasing Community Services)

Amount, Duration, and Scope

Section 1902(a)(10)(B)

To the extent necessary, to enable the state to provide a limited benefit package to demonstration participants in the limited benefit family planning.

Title XIX Requirements Not Applicable to Demonstration Population 11 (Family Planning) only:

Methods of Administration: Transportation

Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53

To the extent necessary to enable the state to not assure transportation to and from providers.

Eligibility Procedures

Section 1902(a)(17)

To the extent necessary to allow the state to not include parental income when determining a minor's (an individual age 18 and below) eligibility.

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

Section 1902(a)(15)

To enable the state to establish payment rates that differ from the PPS to be used for family planning and family planning-related services furnished to women enrolled in Demonstration Population 11 (Family Planning).

Retroactive Eligibility

Section 1902(a)(34)

To the extent necessary, to exempt the state from extending eligibility prior to the date of application for Demonstration Population 11 (Family Planning).

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

Section 1902(a)(43)

To the extent necessary, to exempt the state from furnishing or arranging for EPSDT services for Demonstration Population 11 (Family Planning).

Title XIX Requirements Not Applicable to the Population in the REM Program

Any Willing Provider

Section 1902(a)(23)(A) insofar as it incorporates 42 CFR 431.55(f)

To the extent necessary, to permit the state to selectively contract with a single entity for the provision of the Rare and Expensive Case Management (REM) benefit as authorized under this demonstration through Expenditure Authority 4. The operation of this selective contracting authority does not affect a beneficiary's ability to select between two or more qualified case managers employed by the selected vendor.