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

The state implements the optional 1915(i) State Plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

**1. Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

- Child and Family Team Participation
- Intensive In-Home Services
- Mobile Crisis Response Services
- Community-Based Respite Care
- Out-of-Home Respite Care
- Family Peer Support
- Expressive and Experiential Behavioral Services
- Behavioral Health Consultation to Health Care Professionals
- Customized Goods & Services

**2. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one)*:

| | | | |
|---|---|---|---|
| ○ | The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*: | | |
| | ○ | The Medical Assistance Unit *(name of unit)*: | |
| | ○ | Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)* *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.* | |
| ● | The State plan HCBS benefit is operated by *(name of agency)* | | |
| | Department of Health and Mental Hygiene – Mental Hygiene Administration | | |
| | a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request. | | |

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**3. Distribution of State plan HCBS Operational and Administrative Functions.**

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

| Function | Medicaid Agency | Other State Operating Agency | Contracted Entity | Local Non-State Entity |
|---|---|---|---|---|
| 1 Individual State plan HCBS enrollment | ☑ | ☐ | ☐ | ☐ |
| 2 State plan HCBS enrollment managed against approved limits, if any | ☑ | ☐ | ☐ | ☐ |
| 3 Eligibility evaluation | ☑ | ☑ | ☑ | ☑ |
| 4 Review of participant service plans | ☑ | ☑ | ☑ | ☑ |
| 5 Prior authorization of State plan HCBS | ☑ | ☑ | ☑ | ☐ |
| 6 Utilization management | ☑ | ☑ | ☑ | ☐ |
| 7 Qualified provider enrollment | ☑ | ☑ | ☑ | ☐ |
| 8 Execution of Medicaid provider agreement | ☑ | ☐ | ☐ | ☐ |
| 9 Establishment of a consistent rate methodology for each State plan HCBS | ☑ | ☑ | ☐ | ☐ |
| 10 Rules, policies, procedures, and information development governing the State plan HCBS benefit | ☑ | ☑ | ☐ | ☐ |
| 11 Quality assurance and quality improvement activities | ☑ | ☑ | ☐ | ☐ |

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

Numbers 3-7 are performed with as-needed assistance from a contracted administrative services organization (ASO) and local Core Service Agencies (CSAs). CSAs are local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level.

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*(By checking the following boxes the State assures that):*

**4.** ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The independent entity contracted with the Department conducts beneficiary eligibility assessments to determine service eligibility and authorized service level. The Department's contract with the Administrative Services Organization (ASO) includes conflict of interest standards to ensure that independent assessors are note related by blood or to, financially reposnsible for, empowered to make financial or health-related decisions on behalf of, or paid caregivers of the beneficiary. The Department's contract with the ASO also includes conflict of interest standards that prohibit the ASO from hiring as independent assessors persons who are providers of the services covered under this 1915(i) HCBS benefit or who have an interest in or are employed by providers of State plan HCBS.

The responsibility of plan of care development is given to the Care Coordination Organization (CCO) in partnership with the Child and Family Team (CFT), with the following conflict of interest protections: 1) The provider must develop a person-centered plan of care with full participation by the beneficiary, legally responsible person, and other family members and informal caregivers, as applicable; and 2) The plan of care must incorporate and address all beneficiary needs identified in the independent assessment.

**5.** ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

**6.** ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

**7.** ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

# Number Served

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

| Annual Period | From | To | Projected Number of Participants |
|---|---|---|---|
| Year 1 | 10/1/14 | 9/30/15 | 200 |
| | | | |
| | | | |
| | | | |
| | | | |

**2.** ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

# Financial Eligibility

**1.** ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.)

**2. Income Limits.**

☑ In addition to providing State plan HCBS to individuals described in item 1 above, the state is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Attachment 2.2A of the state plan). Choose one:

☑ The state covers all individuals described in items 2(a) and 2(b) as described in Attachment 2.2-A of the state plan.

or

☐ The state covers only the following group individuals described below as specified in Attachment 2.2-A of the state plan. Choose (a) or (b):

(a) ☐ Individuals not otherwise eligible for Medicaid who meets the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

or

(b) ☐ Individuals who would meet the criteria for a 1915(c) or 1115 waiver and whose income does not exceed 300% of the supplemental security income benefit rate. Complete (i) and/or (ii).

i. (☐ Specify the 1915(c) Waiver/Waivers CMS Base Control Number/Numbers for which the individual would be eligible: ___

and/or

ii. ☐ Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible:

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# Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

| | |
|---|---|
| ○ | Directly by the Medicaid agency |
| ● | By Other (*specify State agency or entity under contract with the State Medicaid agency*): |
| | The Mental Hygiene Administration, in conjunction with a contracted administrative services organization, and Core Services Agencies, the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level. |

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The 1915(i) program will use Maryland's definitions of serious emotional disability along with specific medical necessity criteria in performing an independent evaluation of needs-based criteria.

The independent evaluation and reevaluation will be completed by the Administrative Services Organization (ASO) on behalf of the Mental Hygiene Administration (MHA). Maryland licensed mental health professionals will review all submitted clinical information, to include a psychiatric assessment and psychosocial assessment dated within the past 30 days, a physical dated within the past 12 months, and an ECSII or CASII score from the Core Service Agency (CSA) based on the psychiatric and psychosocial assessments. The ASO will additionally gather additional information by telephone or other electronic means when needed, and compare the information with the Maryland Medicaid Medical Necessity Criteria for each level of care and type of request. Training will be required for the use of any standardized tools, including the Early Childhood Service Intensity Instrument (ECSII) and the Child and Adolescent Service Intensity Instrument (CASII). After verifying eligibility for the 1915(i) HCBS with the Medicaid Eligibility Unit, the ASO will pre-authorize all of the medically appropriate behavioral health services.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The Administrative Services Organization (ASO), on behalf of the Mental Hygiene Administration will verify eligibility, perform the independent evaluation of needs-based criteria, and pre-authorize all of the medically appropriate mental health services. The evaluation will be conducted by a licensed mental health professional and based upon Maryland's definition of medically necessary treatment which requires services or benefits to be (1) directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition; (2) consistent with currently accepted standards of good medical practice; (3) the most cost efficient service that can be provided without sacrificing effectiveness or access to care; and (4) not primarily for the convenience of the consumer, family, or provider. The evaluator will be familiar with the medical necessity criteria and will use those criteria and the individual's clinical history to determine

eligibility. The evaluator will utilize a psychiatric assessment and psychosocial assessment to generate a score on the ECSII or CASII for the youth, and will compare that to the score generated by the Core Service Agency based on the same documentation. If necessary, the evaluator will gather additional information by telephone or other means in conjunction with the CSA.

Specific eligibility criteria, including re-evaluation criteria, are outlined in #4 below.

Once eligibility for services has been determined, a Care Coordination Organization will work with the child and family to develop an individualized Plan of Care (POC) that is consistent with the principles of Wraparound (i.e. strengths-based, individualized, community-based, etc), as defined by the National Wraparound Initiative. The POC will be reviewed by the Child and Family Team at least every 45 days, with a review by the ASO when there is a change to the POC that necessitates a pre-authorization. The ASO will review at least the most recent POC along with other documentation at least annually as part of the review for continued eligibility for services.

**4.** ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

**5.** ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The following are the minimum requirements that a child or youth must demonstrate to be considered for 1915(i) services:

1. Age: Youth must be under 18 years of age at the time of enrollment although they may continue in HCBS Benefit up to age 22.
2. Residence:
   a. Youth must reside in a home- and community-based setting. Excluded Community programs in which a youth may not reside while receiving the 1915(i) HCBS Benefit are: (1) Therapeutic Group Home (TGH) licensed by the Office of Health Care Quality (OHCQ) under COMAR 10.21.07; (2) a Psychiatric Respite Care facility located on the grounds on an IMD for the purpose of placement; (3) residential program for adults with serious mental illness licensed under COMAR 10.21.22.
   b. During the initial phase-in of the HCBS benefit, youth must reside in one of the geographic areas in Maryland where the 1915(i) HCBS benefit is available.
3. Consent:
   a. Youth under 18 must have consent from the parent or legal guardian to participate; for young adults who are 18 or older and already enrolled, the young adult must consent to participate. Youth over 18 who are in the care and custody of the State, require consent from their legal guardian.
   b. The consent to participate includes information on the array and availability of services, data collection and information-sharing, and rights and responsibilities under Maryland Medical Assistance.
4. Behavioral Health Disorder:
   a. Youth must have a behavioral health disorder amenable to active clinical

treatment. The evaluation and assignment of a Diagnostic and Statistical Manual (DSM) diagnosis must result from a face-to-face psychiatric evaluation that was completed or updated within 30 days of submission of the application to the Department or its designee.

b. There must be clinical evidence the child or adolescent has a serious emotional disturbance (SED) and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment. Because of the clinical requirement that the young person have an SED in order to be covered under the Program, the State will require the young person to be actively involved in ongoing mental health treatment on a regular basis in order to receive 1915(i) services.

5. Impaired Functioning & Service Intensity: A licensed mental health professional (LMHP) must complete or update a comprehensive psychosocial assessment within 30 days of the submission of the application to the ASO. The psychosocial assessment must outline how, due to the behavioral health disorder(s), the child or adolescent exhibits a significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, and/or community. The serious harm does not necessarily have to be of an imminent nature. The psychosocial assessment must support the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-21.
    a. Youth must receive a score of:
        i. 4 (High Service Intensity) or 5 (Maximal Service Intensity) on the ECSII or
        ii. 5 (Non-Secure, 24-Hour, Medically Monitored Services) or 6 (Secure, 24-Hours, Medically Managed Services) on the CASII
    b. Youth with a score of 5 on the CASII also must meet one of the following criteria to be eligible based on their impaired functioning and service intensity level:
        i. Transitioning from a Residential Treatment Center;
        ii. Living in the community and
            1. At least 13 years old and have
                a. 3 or more inpatient psychiatric hospitalizations in the past 12 months or
                b. Been in an RTC within the past 90 days.
            2. Age 6 through 12 years old and have
                a. 2 or more inpatient psychiatric hospitalizations in the past 12 months or
                b. Been in an RTC within the past 90 days.
    c. Youth who are younger than 6 years old who have a score of a 4 on the ECSII either must:
        i. Be referred directly from an inpatient hospital unit or
        ii. If living in the community, have two or more psychiatric inpatient hospitalizations in the past 12 months.
6. Other Community Alternatives: The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the DHMH or its designee.
7. Duplication of Services: The youth may not be enrolled in another 1915(c) HCBS Waiver, an Adult Residential Program for Adults with Serious Mental Illness licensed under COMAR 10.21.22 or a Health Home while enrolled in the HCBS benefit.

The medical re-evaluation, including a CASII or ECSII review, will be completed by the ASO based on:

1. An updated psychosocial assessment from a treating mental health professional supporting the need for continued HCBS benefit services;
2. A CASII or ECSII review by a licensed mental health professional at the Care Coordination Organization (with a CASII score of 5 or 6 or ECSII score of 4 or 5); and,
3. A review of HCBS benefit service utilization over the past 6 months.

Youth will not be eligible for HCBS services if they meet one or more of the following criteria:

1. Youth is hospitalized for longer than 30 days. During this period, only care coordination will be permitted as a non-duplicative service, subject to ASO approval.
2. Youth moves out of state for more than 30 days.
3. During the initial phase-in of the 1915(i) HCBS benefit, youth moves out of a geographic area within the State of Maryland where the youth cannot reasonably access services and supports.
4. Youth is admitted to and placed in an RTC for longer than 60 days. Only care coordination will be permitted during this time as a non-duplicative service, subject to ASO approval.
5. Youth is admitted to and placed in a Therapeutic Group Home (TGH) licensed by OHCQ under COMAR 10.21.07 or an adult residential program approved under COMAR 10.21.22.
6. Youth is placed in a Psychiatric Respite Care program, a non-medical group residential facility located on the grounds of an IMD primarily for the purpose of placement.
7. Youth loses eligibility for Maryland Medical Assistance for more than 30 days [State general funds—uninsured status—will be used during the 30 days after MA coverage lapses]
8. Youth turns 22 years old.
9. Youth is detained, committed to a facility, or incarcerated for longer than 60 days [note: only care coordination will be permitted during this time as a non-duplicative service, and only if the youth is in detention pending placement into a community-based placement per Department of Human Resources Family Investment Administration Action Transmittal 11-19.
10. Youth's annual Medical Review does not meet medical re-certification criteria.
11. There is no Child and Family Team (CFT) meeting held within 90 days.
12. The youth is no longer actively engaged in ongoing mental health treatment with a licensed mental health professional.
13. Youth is over age 18 and has either never been enrolled in the 1915(i) program, or was disenrolled more than 120 days prior to re-application.

**6.** ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

| State plan HCBS needs-based eligibility criteria | NF (& NF LOC** waivers) | ICF/MR (& ICF/MR LOC waivers) | Applicable Hospital* (& Hospital LOC waivers) |
|---|---|---|---|
| The needs-based eligibility criteria are described in #4. | Maryland allows reimbursement to nursing homes for eligible persons who require hospital care, but who, because of their mental or physical condition, require skilled nursing care and related services, rehabilitation services, or, on a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities. Md. Code Reg. 10.09.10. | Md. Code Reg. 10.22.01.01 contains the following definitions:<br>(2) “Alternative living unit (ALU)” means a residence owned, leased, or operated by a licensee that:<br>(a) Provides residential services for individuals who, because of a developmental disability, require specialized living arrangements;<br>(b) Admits not more than 3 individuals; and<br>(c) Provides 10 or more hours of supervision per unit, per week.<br>(25) "Group home" means a residence owned, leased, or operated by a licensee that:<br>(a) Provides residential services for individuals who, because of a developmental disability, require specialized living arrangements;<br>(b) Admits at least four, but not more than eight individuals; and<br>(c) Provides 10 or more hours of supervision per week.<br>(16) “Developmental disability" as a chronic disability of an individual that:<br>(a) Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;<br>(b) Is likely to continue indefinitely;<br>(c) Is manifested in an individual younger than 22 years old;<br>(d) Results in an inability to live independently without external support | For inpatient hospital psychiatric emergency detention or involuntary admission, Md. Health Gen. §§ 10-613 through 619<br>requires that: (1) the individual has a mental disorder; (2) the individual needs inpatient care or treatment; (3) The individual presents a danger to the life or safety of the individual or of others; (4) The individual is unable or unwilling to be admitted voluntarily; and; (5) There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.<br><br>For voluntary admission to a psychiatric hospital, the requirements of Md. Health Gen. §§ 10–609 and 10-610 for minors must be met, including a formal, written application. A facility may not admit an individual under this section unless: the (1) individual has a mental disorder; (2) The mental disorder is susceptible to care or treatment; (3) The individual understands the nature of the request for admission; (4) The individual is able to give continuous assent to retention by the facility; and (5) The individual is able to ask for release. |

| | | | |
|---|---|---|---|
| | | or continuing and regular assistance; and<br>(e) Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are individually planned and coordinated for the individual. | |

*Long Term Care/Chronic Care Hospital

**LOC= level of care

**7.** ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). (*Specify target group(s)*):

This HCBS benefit is targeted to youth and young adults with serious emotional disturbances (SED) and their families, as described in the above Needs Based eligibility criteria.

*(By checking the following boxes the State assures that):*

**8.** ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

**9.** ☑ **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The state attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets home and community-based setting requirements as defined by the state and approved by CMS. (If applicable, specify any residential settings, other than an individual's home or apartment, in which 1915(i) participants will reside. Describe the home and community-based setting requirements that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):

Participants in the HCBS benefit either will reside in

1) a home or apartment that is not owned, leased or controlled by a provider of any health-related treatment or support services;
2) a home or apartment that is a foster home, treatment foster home, independent living home, kinship home, or home of an individual otherwise receiving room and board payments from the State for the care of the participant;
3) a residential child care facility, which is subject to §1616(e) of the Social Security Act, other than a therapeutic group home or psychiatric respite care facility.

Applicants to become a Residential Child Care Facility are required to submit a proposal to the Single Point of Entry in the Governor's Office for Children, explaining how they will make their facility feel like a home-like environment and how residents will be supported to attend community schools and programs, receive services from community providers, and have family visits (COMAR 14.31.05-.07). Each Residential Child Care Facility has a policy manual that is approved by its licensing agency that provides extensive detail on the daily living arrangement for residents.

The State's standards for Residential Child Care Facilities address all of the following topics: Admission policies; physical environment; sanitation; safety; staff: resident ratios; staff training and qualifications; staff supervision; resident rights; medication administration; use of restrictive interventions; incident reporting; and, provision of or arrangement for necessary health services.

If a youth is living in an out-of-home placement, including a treatment foster home or a Residential Child Care Facility (aka, a group home), or receiving Residential Rehabilitation Services, the State of Maryland will not utilize Medicaid funding for these placements while the youth is enrolled in the 1915(i) HCBS benefit.

Youth will not be eligible to receive services under the HCBS benefit if they reside in a psychiatric respite facility or a therapeutic group home. Youth may only receive care coordination services during the time that they reside in a PRTF or hospital, for up to 30 days. Youth who are detained, committed to a facility, or incarcerated may continue to receive care coordination services for up to 60 days subject to ASO approval.

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# Person-Centered Planning & Service Delivery

*(By checking the following boxes the state assures that):*

**1.** ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent who is independent and qualified;
- A person-centered process and guided by best practice and research on effective strategies that result in improved health and quality of life outcomes;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals responsible for the individual's care;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the person-centered service plan;
- An examination of the individual's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the person-centered service plan, a caregiver assessment;
- If the state offers individuals the option to self-direct state plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

**2.** ☑ Based on the independent assessment, the individualized person-centered service plan:

- Is developed with a person-centered process jointly with the individual and if applicable, the individual's authorized representative, and others chosen by the individual. The person-centered planning process:
    - Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
    - Is timely and occurs at times and locations of convenience to the individual.
    - Reflects cultural considerations of the individual;
    - Includes strategies for solving conflict or disagreement with the process, including clear conflict of interest guidelines for all planning participants;
    - Offers choices to the individual regarding the services and supports they receive and from whom;
    - Includes a method for the individual to request updates to the plan, as needed; and
    - Records the alternative home and community-based settings that were considered by the individual.
- Reflects the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.
- Reflect that the setting in which the individual resides is chosen by the individual.
- Reflects the individual's strengths and preferences.
- Reflects clinical and support needs as identified through an assessment of functional need.
- Includes individually identified goals and desired outcomes.

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- Reflects the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.
- Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- Is understandable to the individual receiving services and supports, and the individuals important in supporting him or her.
- Identifies the individual and/or entity responsible for monitoring the plan.
- Is finalized and agreed to, with the informed consent of the individual, in writing by the individual and signed by all individuals and providers responsible for its implementation.
- Is distributed to the individual and other people involved in the plan.
- Includes those services, the purchase or control of which the individual elects to self-direct.
- Prevents the provision of unnecessary or inappropriate services and supports.

**3.** Is reviewed at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Care Coordinators will be responsible for conducting a face-to-face assessment of an individual's support needs and capabilities. Care Coordinators are employed by the Care Coordination Organizations (CCOs) and have met all the requirements of being a care coordinator under a CCO as specified below.

**4.** **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Participants in this State Plan HCBS benefit will participate in the Wraparound practice model, facilitated by the CCO. Qualifications for Care Coordination Organizations will be described in future state regulation (COMAR 10.09.90), and all 1915(i) participants are required to receive care coordination services under the same regulations. However, the plan of care (POC) development is the responsibility of the Child/Youth and Family Team (CFT) as described below. The Clinical Director, a licensed mental health professional, will supervise the development and ongoing implementation of the POC and review and approve the POC.

The CFT is a core element in the Wraparound practice model. The CFT is comprised of the CCO, child or youth (as appropriate), caregiver(s), support persons identified by the family (paid and unpaid), and service providers, including the youth's treating clinician. The CFT meets at least every 45 days and revisits and updates the POC at each CFT meeting. The CCO is responsible to meet with the child/youth and family more frequently in between CFT meetings. POCs are updated within 5 days of the CFT and are distributed to all team members including the participant and his or her family members. Additionally, there are copies in the child's or youth's file (electronic and/or paper).

There are a variety of assessments used to develop the POC, including information collected during the application process, and all life domains are incorporated into the POC. The Child and Adolescent Needs and Strengths (CANS) is administered every 90 days by the CCO supervisor to support communication among CFT members and identification of strengths and needs for care planning. Information from the family and their identified supports is incorporated as a part of the

process.

5. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The child's/youth's family is informed verbally and in writing about overall services available in the State Plan HCBS benefit at the time they make the choice to enroll. The specific services for each child or youth are an outcome of the development of the Plan of Care (POC) and are Child/Youth and Family Team (CFT) - determined, based on medical necessity for Medicaid services and supports. Caregivers and youth (depending on age or cognitive development) are at the table for the development of the POC. One of the key philosophies in the Wraparound process is family-determined care. This means that parent(s) or legal guardian, youth and family members are the primary decision makers in the care of their family.

Within 72 hours of notification of enrollment, the Care Coordination Organization (CCO) contacts the participant and family to schedule a face-to-face meeting. At the first meeting between the CCO and participant and family after enrollment, the CCO will:

(a) Administer the appropriate assessments, as designated by the Mental Hygiene Administration (MHA);
(b) Work with the participant and family to develop an initial crisis plan that includes response to immediate service needs;
(c) Provide an overview of the wraparound process; and
(d) Facilitate the family sharing their story.

The first CFT meeting will occur within 30 days of State Plan HCBS benefit enrollment. Prior to the first Child/Youth Family Team (CFT) meeting, the CCO will, with the participant and family: identify needs that they will work on in the planning process; determine membership for the CFT; contact potential team members, provide them with an overview of the wraparound process, and discuss expectations for the first CFT meeting; conduct an initial assessment of strengths of the participant, their family members and potential team members; and, determine the vision statement with the family.

The CFT, which includes the participant and his or her family and informal and formal supports, will determine the family vision which will guide the planning process; identify strengths of the entire team; determine the needs that the team will be working on; determine outcome statements for meeting identified needs; determine the specific services and supports required in order to achieve the goals identified in the POC; create a mission statement that the team generates and commits to following; identify the responsible person(s) for each of the strategies in the POC; review and update the crisis plan; and, meet at least every 45 days to coordinate the implementation of the POC and update the POC as necessary.

Before the provision of services in the POC, MHA or its designee shall review and authorize the services designated in the POC. The CFT shall reevaluate the POC at least every 45 days with re-administration of MHA-approved assessments as appropriate. During the development of the plan of care, family members and other supports identified by the family also participate as a part of the team. These participants may change as the child's or youth's needs change particularly as he/she is

transitioning out of the formal Wraparound services. The participant/family will sign a document that is part of the POC next to the statement that reads, "My family had voice and choice in the selection of services, providers and interventions, when possible, in the Wraparound process of building my family's Plan of Care."

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

MHA or its designee will have and maintain a database and/or directory available to the CCO and CFT from which to choose providers to implement the plan of care. Providers are selected by CFT with the support of the CCO. Participants are active members of the CFT who will, depending on age and/or cognitive development, assist in the selection of providers based on the POC and the expertise of the team members. There will be an ongoing enrollment of providers to ensure the capacity is available.

7. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service is made subject to the approval of the Medicaid agency):*

The CCO is responsible for monitoring the implementation of plans of care by service providers. This is done as a part of the CFT meetings that occur at least every 45 days. MHA will sample plans of care, review participant records, and track and trend the results of quality management activities as part of the quality assurance plan outlined below. MHA will document the results of ongoing monitoring activities in quarterly and annual reports that are provided to the Medicaid Agency. The Medicaid Agency will review the quarterly and annual reports that are prepared by MHA. To address any service deficiencies, the Medicaid Agency will work in collaboration with MHA, the CCO, and members of the CFT as appropriate, to implement any necessary changes to a participant's plan of care, prepare letters to providers that document deficiencies, and impose provider sanctions as needed.

8. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Medicaid agency | ☐ | Operating agency | ☐ | Case manager |
| ☑ | Other (*specify):* | Care Coordination Organization | | | |

# Services

**b. State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

| **Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):* | |
|---|---|
| Service Title: | **Child and Family Team (CFT) Participation** |
| Service Definition (Scope)*:* | |
| Child and Family Team (CFT) Participation is the participation in-person or by pre-approved electronic or telephonic methods in the Child and Family Team meeting by an identified member of | |

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| the CFT, according to the Plan of Care. |
| Additional needs-based criteria for receiving the service, if applicable *(specify):* |
| N/A |
| Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):* |

| | |
|---|---|
| ☑ | Categorically needy *(specify limits):* |
| | CFT participation may be provided on the same day as another HCBS benefit or PMHS service by the same provider. The services provided under CFT participation may not be duplicative of other Public Mental Health System or HCBS benefit services. |
| ☐ | Medically needy *(specify limits):* |
| | |

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| **CFT** | N/A | N/A | All CFT members will be service providers in good standing with Maryland Medicaid. |

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

| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
|---|---|---|
| **Child and Family Team Participation** | Authorization and verification will be done by the Administrative Service Organization, on behalf of the Mental Hygiene Administration | Annual representative sample |

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

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | ☑ | Provider managed |

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Intensive In-Home Services**

Service Definition (Scope)*:*

Intensive In-Home Services (IIHS) is a strengths-based intervention with the child and his or her identified family which may include biological family members, foster family members, treatment foster family members, or other individuals with whom the youth resides. When approved for this service, the IIHS provider sees the family and/or youth at least once each week. IIHS includes a series of components, including functional assessments and treatment planning, individualized interventions, crisis response and intervention, and transition support. IIHS may be provided to the child alone, to other family members, and to the child and family members together. The IIHS treatment plan must be integrated with the overall POC, and the IIHS providers must work with the CFT and family to transition out of the intensive service.

IIHS is intended to support a child to remain in his or her home and reduce hospitalizations and out-of-home placements or changes of living arrangements through focused interventions in the home and community. Examples of situations in which IIHS may be used include: at the start of a child's enrollment in the HCBS benefit, upon discharge from a hospital or residential treatment center, or to

prevent a crisis situation, or stabilize the participant after such a crisis.

IIHS includes a crisis service component, with IIHS providers immediately available 24 hours per day, 7 days each week to provide services as needed to prevent, respond to, or mitigate a crisis situation. If the crisis cannot be defused, the IIHS provider is responsible for assisting the family in accessing emergency services immediately for that child.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

The service is automatically authorized for 60 days for any individual meeting the eligibility criteria of this 1915(i) State Plan Amendment. Thereafter, the services will be authorized in six month increments. IIHS may not be billed on the same day as Mobile Crisis Response Services (MCRS), Mobile Treatment Services (MTS), partial hospitalization (day treatment), family therapy (not including individual therapy, medication management, or group therapy), an admission to an inpatient hospital or residential treatment center, or therapeutic behavioral services. The services provided under IIHS may not be duplicative of other Public Mental Health System or HCBS benefit services.

☐ Medically needy *(specify limits):*

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| **Intensive In-Home** | Health Occupations Article, Annotated Code of Maryland and COMAR 10.21.19, 10.21.29, 10.21.09, 10.21.20, 10.27.12 | Certificate from national or intermediate purveyor | All providers must have a certificate or letter from the national or intermediate purveyor or developer of the particular evidence-based practice or promising practice or from DHMH to demonstrate that the provider meets all requirements for the specific type of Intensive In-Home Service, including but not limited to the requirements for quality assurance, auditing, monitoring, data collection and reporting, fidelity monitoring, participation in outcomes evaluation, training, and staffing, as outlined in regulation.<br><br>The Department of Health and Mental Hygiene will maintain a publicly available list of practices that meet the criteria for intensive in-home services, including but not limited to Functional Family Therapy (FFT) and In-Home Intervention Program for Children (IHIP-C). |

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|---|---|---|---|
| | | | Providers of Intensive In-Home Services must ensure that<br>1) There are Clinical Leads, Supervisors, and Therapists on staff who are responsible for creating, implementing and managing the treatment plan with the child and family and the CFT;<br>2) On-call and crisis intervention services are:<br>i) Provided by a licensed mental health professional (psychiatrist, psychologist, nurse psychotherapist, advanced practice registered nurse - psychiatric mental health (APRN-PMH), LCSW-C, LCSW, or LCPC) trained in the intervention; and,<br>ii) Available 24-hours per day, 7 days per week, during the hours the provider is not open to the individual enrolled in the treatment; and,<br>iii) The program complies with staffing, supervision, training, data collection and fidelity monitoring requirements set forth by the purveyor, developer, or DHMH and approved by the Department.<br>3) Clinical Leads and Supervisors must:<br>a) Have a current license as a licensed certified social worker-clinical (LCSW-C), licensed clinical professional counselor (LCPC), psychologist, psychiatrist, nurse psychotherapists, or advanced practice registered nurse/psychiatric mental health (APRN/PMH) under the Health Occupations Article, Annotated Code of Maryland; and,<br>b) Have at least three years of experience in providing mental |

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| | | | health treatment to children and families.<br>4) Therapists must:<br>a) Have a current license as a licensed certified social worker (LCSW), LCSW-C, LCPC, psychologist, psychiatrist, nurse psychotherapist, or APRN/PMH under the Health Occupations Article, Annotated Code of Maryland;<br>b) Be supervised by a Clinical Lead or Supervisor;<br>c) See the child in-person at least once in a seven (7) day period<br>5) In-home stabilizers<br>a) Support the implementation of the treatment plan, but are not responsible for creating it or modifying it;<br>b) Must be at least 21 years old;<br>c) Must have at least a high school diploma or equivalency,; and<br>d) Must have completed relevant, comprehensive, appropriate training prior to providing services, as outlined by the purveyor, developer, or DHMH and approved by DHMH.<br><br>Licensed mental health providers are subject to all the rules and regulations in the Maryland Health Occupations Article and to the oversight of their respective licensing boards. The IIHS provider may be a provider of Mobile Treatment Services, an Outpatient Mental Health Clinic, or a Psychiatric Rehabilitation Program for Minors. |

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

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

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

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | ☑ | Provider managed |

| **Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):* | |
|---|---|
| Service Title: | **Mobile Crisis Response Services (MCRS)** |
| Service Definition (Scope)*:* | |

Mobile Crisis Response Services (MCRS) are interventions for participants and families that:
(a) Are offered in response to urgent mental health needs, as defined by the child and/or family;
(b) Are available on an immediate, on-call basis 24 hours per day, 7 days per week;
(c) Are incorporated into the participant's Plan of Care;
(d) Are short-term, individualized services that assist in de-escalating crises and stabilizing children and youth in their home and community setting;
(e) Are designed to maintain the child or youth in his or her current living arrangements, to prevent movement from one living arrangement to another and to prevent repeated hospitalizations;
(f) Include the delivery of a variety of services in accordance with a comprehensive, individualized plan for stabilization that:
(i) Addresses safety concerns and risk factors, including the family's definition of the crisis;
(ii) Includes family triggers, strengths, and supports; and,
(iii) Identifies both immediate and continued interventions to ensure stabilization in the home and community setting, which may include strategies to de-escalate and prevent a crisis situation, short-term in-home therapy, behavioral management and support, coordination and development of natural supports, and skills training on coping and activities of daily living.

MCRS may be provided in any community location to prevent emergency room visits, hospitalization or movement from one living arrangement to another, including but not limited to, the family home, foster home, or group home.

The MCRS provider will triage the call and dispatch an MCRS crisis responder to the location where the crisis is occurring, if the crisis has not been de-escalated over the phone and the MCRS provider has determined that an in-person response is necessary based on established best practices in crisis response and the family's individual definition of a crisis. The MCRS provider must determine if a crisis responder should be dispatched, and the crisis responder must be contacted immediately to travel to the location where the crisis is occurring. The MCRS crisis responder will assess the situation, including the potential for danger that the child poses to him/herself or others. The crisis responder will de-escalate the crisis and support the child and family to be stabilized. If the crisis cannot be de-escalated, the crisis responder will contact the police to ensure the safety of the child and family.

There are three components of MCRS that can be billed, in addition to the CFT Participation, are:

- Assessment: Conducted prior to a crisis, in coordination (and together, where possible) with the Care Coordination Organization to develop an initial crisis plan within the first week of enrollment in the HCBS Benefit
- Crisis Response: In-person response to the location where a crisis is occurring to assess, de-escalate, and provide initial stabilization.
- Stabilization: In-person support for up to two weeks following a crisis response to support revisions to the crisis plan and provide education and training on preventing and responding to crises. Stabilization may also be provided at the recommendation of the CFT to prevent a crisis, and must be authorized separately by the ASO.

MCRS providers are strongly encouraged to participate in the CFT process prior to a crisis occurring, and are expected to attend and participate in the CFT meeting after a crisis occurs. Attendance and participation in the CFT meetings may be billed in accordance with the conditions and limitations of that rate.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

All HCBS benefit participants will be pre-authorized to receive an MCRS assessment. Upon completion of the assessment, all participants will be pre-authorized to receive a crisis response with a three day authorization. The MCRS provider must then request prior authorization from the Administrative Service Organization to provide ongoing crisis stabilization services. A participant who is receiving IIHS may not receive MCRS. The services provided under MCRS may not be duplicative of other Public Mental Health System or HCBS benefit services, and a participant who is receiving MCRS may not receive mobile treatment services on the same date.

☐ Medically needy *(specify limits):*

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| **MCRS** | Health Occupations Article, Annotated Code of Maryland and COMAR 10.21.19, 10.21.29, 10.21.09, 10.21.20, 10.27.12 | N/A | In order to provide MCRS, the provider must be approved by the State of Maryland as one of the following:<br>1) A provider of<br>a) Mobile Treatment Services, as outlined in COMAR 10.21.19;<br>b) Psychiatric Rehabilitation Services for Minors, as outlined in COMAR 10.21.29;<br>2) An Outpatient Mental Health Clinic (OMHC), as outlined in COMAR 10.21.20.<br><br>MCRS providers must have clinical supervisors that are licensed in good standing under Health Occupations Article, Annotated Code of Maryland, as a psychiatrist, psychologist, licensed certified social worker-clinical (LCSW-C), licensed clinical professional counselor (LCPC), nurse psychotherapist, or Advanced practice registered nurse/psychiatric mental health (APRN/PMH). Crisis responders must be psychiatrists, psychologists, LCSW-C, licensed certified social workers (LCSW), |

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| | | | nurse psychotherapists, or Advanced practice registered nurse/psychiatric mental health (APRN/PMH), as outlined in the Health Occupations Article, Annotated Code of Maryland.<br><br>After the crisis has been stabilized, crisis stabilizers may assist in stabilizing the child and family using the treatment plan developed by the crisis responder with the family. Crisis Stabilizers must be at least 21 years old, have a bachelor's degree in a human service field, and receive initial and ongoing training in crisis response and stabilization. |

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

| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
|---|---|---|
| **Mobile Crisis Response Services** | Office of Health Care Quality will perform initial verification of license or approval.<br>Administrative Service Organization on behalf of the Mental Hygiene Administration | OHCQ: At the time of enrollment and at least every three years<br>ASO: At the time of enrollment and through a representative sample annually |

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

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | ☑ | Provider managed |

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Community-Based Respite Care**

Service Definition (Scope)*:*

Community-Based Respite Services are temporary care services arranged on a planned or unplanned basis. Respite provides stabilization and relieves a caregiver from the stress of care giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help mitigate a potential crisis situation. These services may be provided in the home or the community. Community-based respite services are consistent with existing State of Maryland regulations for in-home respite care which is paid for using State-only dollars (COMAR 10.21.27).

Respite care services are those that are:
(1) Provided on a short-term basis in a community-based setting; and
(2) Designed to support an individual to remain in the individual's home by:
(a) Providing the individual with enhanced support or a temporary alternative living situation, or
(b) Assisting the individual's home caregiver by temporarily freeing the caregiver from the responsibility of caring for the individual.

Additionally, the respite services are designed to fit the needs of the individuals served and their caregivers. A program may provide respite care services as needed for an individual based on the Child/Youth and Family Team's Plan of Care (POC). The specific treatment plan for the community-based respite care should outline the duration, frequency, and location and be designed with a planned conclusion.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

Community-based respite services are available to children receiving the HCBS benefit who are residing in his or her family home (biological or kin), legal guardian's home, pre-adoptive/adoptive, or foster home. Community-based respite services do not include on-going day care or before or after school programs. Community-based respite services are not available to children residing in residential child care facilities (COMAR 14.31.05-.07) or treatment foster homes.

The service is automatically authorized for 60 days for any individual meeting the eligibility criteria of this 1915(i) State Plan Amendment. Thereafter, the services will be authorized in six month increments. A minimum of one hour of the service must be provided to bill, up to a maximum of six hours per day. The services provided under Community-Based Respite Care may not be duplicative of other Public Mental Health System or HCBS benefit services, and will not be paid on the same day as therapeutic behavioral services (COMAR 10.09.34) or any other public mental health system respite services.

☐ Medically needy *(specify limits):*

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| **Community-Based Respite Care** | N/A | N/A | Community-Based Respite Care Providers must<br>A. Meet the in-home respite care requirements of COMAR 10.21.27, as determined by the Department of Health and Mental Hygiene;<br>B. Ensure that respite care staff are:<br>1) At least 21 years old and have at least a high school diploma or high school equivalency; or<br>2) At least 18 years old and enrolled in, or in possession of at least an associate's degree from, an accredited post-secondary educational institution in a human services field, and are |

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|---|---|---|---|
| | | | limited to providing services to participants under 13 years of age.<br>C. Ensure that community-based respite services are provided in the participant's home or other community-based setting; and,<br>D. Follow the program model requirements outlined in COMAR 10.21.27.04-.08 for screening, assessment, staff training and expertise, provision of care, and conclusion of respite episode.<br><br>Providers are approved by the Department of Health and Mental Hygiene. |

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

| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
|---|---|---|
| **Community-Based Respite Care** | Office of Health Care Quality Initial verification of license or approval<br>Administrative Service Organization on behalf of the Mental Hygiene Administration | OHCQ: At the time of enrollment and at least every three years<br>ASO: At the time of enrollment and through a representative sample annually |

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

| | | | |
|---|---|---|---|
| ☑ | Participant-directed | ☑ | Provider managed |

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Out-of-Home Respite**

Service Definition (Scope)*:*

Out-of-Home Respite Services are temporary care which is arranged on a planned or unplanned basis. Respite provides stabilization and relieves a caregiver from the stress of care-giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help mitigate a potential crisis situation. Out-of-home respite is provided in community-based alternative living arrangements that are appropriately licensed, registered, or approved, based on the age of individuals receiving services, and whether the respite has capacity to do overnight services. Out-of-home respite services may not be provided in an institutional setting or on a hospital or residential facility campus. The services provided under Out-of-Home Respite Care may not be duplicative of other Public Mental Health System or HCBS benefit services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

| Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):* | |
|---|---|
| ☑ | Categorically needy *(specify limits):* |
| | Out-of-Home respite services only are available to children receiving the HCBS benefit who are residing in his or her family home (biological or kin), legal guardian's home, pre-adoptive/adoptive, or foster home. Out-of-home respite services are not available to children residing in residential child care facilities (COMAR 14.31.05-.07) or treatment foster homes. Out-of-home respite services do not include on-going day care or before or after school programs.<br><br>The service is automatically authorized for 60 days for any individual meeting the eligibility criteria of this 1915(i) State Plan Amendment. Thereafter, the services will be authorized in six month increments. Out-of-home respite must be provided in a community-based alternative living arrangement outside of the child's home and must be provided for a minimum of twelve hours overnight in order to bill. Participants may receive a maximum of 24 overnight units of out-of-home respite services annually. |
| ☐ | Medically needy *(specify limits):* |
| | |

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| **Out-of-home respite** | N/A | N/A | Out-of-Home Respite Care Providers must:<br>B. Meet the out-of-home respite care requirements of COMAR 10.21.27, as determined by the Department of Health and Mental Hygiene.<br>C. Ensure that respite care staff are:<br>1) At least 21 years old and have at least a high school diploma or high school equivalency; or<br>2) At least 18 years old and enrolled in, or in possession of at least an associate's degree from, an accredited post-secondary educational institution in a human services field, and are limited to providing services to participants under 13 years of age.<br>D. Ensure that out-of-home respite services are provided in a community-based alternative living arrangement outside the participant's home, in |

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| | | | accordance with COMAR 14.31.05-.07, where applicable.<br>E. Follow the program model requirements outlined in COMAR 10.21.27.04-.08 for screening, assessment, staff training and expertise, provision of care, and conclusion of respite episode.<br><br>Providers are approved by the Department of Health and Mental Hygiene. |

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

| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
|---|---|---|
| **Out-of-Home Respite Care** | Office of Health Care Quality Initial verification of license or approval<br>Administrative Service Organization on behalf of the Mental Hygiene Administration | OHCQ: At the time of enrollment and at least every three years<br>ASO: At the time of enrollment and through a representative sample annually |

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

| | | | |
|---|---|---|---|
| ☑ | Participant-directed | ☑ | Provider managed |

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Family Peer Support**

Service Definition (Scope)*:*

Family Peer Support is delivered on an individualized basis by a Peer Support Partner who will do some or all of the following, depending on the Plan of Care:

- Explain role and function of the Family Support Organization (FSO) to newly enrolled families and create linkages to other peers and supports in the community
- Work with the family to identify and articulate their concerns, needs, and vision for the future of their child
- Ensure family opinions and perspectives are incorporated into Child/Youth Family Team process and Plan of Care through communication with CCO and Team Members
- Attend Child/Youth Family Team meetings with the family to support family decision making and choice of options
- Listen to the family express needs and concerns from peer perspective and offer suggestions for engagement in the Wraparound process
- Provide ongoing emotional support, modeling and mentoring during all phases of the Child/Youth Family Team process
- Help family identify and engage its own natural support system

- Facilitate the family attending peer support groups and other FSO activities throughout POC process
- Work with the family to organize, and prepare for meetings in order to maximize the family's participation in meetings
- Inform the family about options and possible outcomes in selecting services and supports so they are able to make informed decisions for their child and family
- Support the family in meetings at school and other locations in the community and during court hearings
- Empower the family to make choices to achieve desired outcomes for their child or youth, as well as the family
- Through one-to-one training, help the family acquire the skills and knowledge needed to attain greater self- sufficiency and maximum autonomy.
- Assist the family in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating the child/youth's behavioral health condition(s), preventing the development of secondary or other chronic conditions, promoting optimal physical and behavioral health, and addressing and encouraging activities related to health and wellness
- Assist in identifying and securing formal and informal resources for the family
- Assist the family in organizing and completing paperwork to secure needed resources
- Educate the family on how to navigate systems of care for their children
- Conduct an assessment related to the need for peer support (including projected frequency and duration) communicate with CCO and other CFT members

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

The service is automatically authorized for one year for any individual meeting the eligibility criteria of this 1915(i) State Plan Amendment. Thereafter, the services will be authorized in six month increments. The services provided under Family Peer Support may not be duplicative of other Public Mental Health System or HCBS benefit services. Family peer support may be provided, and billed, for meeting with the family in-person as well as for communicating with the family over the phone. Family peer support may not be billed for telephonic communications with other providers or resources. Service limits for peer support as follows: Face to face family support limited to 11 hours per month and telephonic peer support limited to 16 hrs monthly, unless specially approved by MHA for higher levels.

☐ Medically needy *(specify limits):*

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| **Family Peer Support** | N/A | Wraparound Certificate Program or certification by the national Certification | Family peer support must be provided by a Family Support Organization (FSO). To be eligible to provide services as an FSO, the organization must: (1) Be a private, non-profit entity designated under 501(c)(3) of the Internal |

| | | | |
|---|---|---|---|
| | | Commission for Family Support which certifies individual Certified Parent Support Providers | Revenue Service Code, and submit copies of the certificate of incorporation and Internal Revenue Service designation;<br><br>(2) Submit a list of members of the board of directors with identification that at least 50% meet the following criteria:<br>a) Are caregivers with a current or previous primary daily responsibility for raising a child or youth with behavioral health challenges; and/or<br>b) Are individuals who have experience with State or local services and systems as a consumer who has or had behavioral health challenges<br><br>(3) Establish hiring practices that give preference to current or previous caregivers of youth with behavioral health challenges and/or individuals who have experience with State or local services and systems as a consumer who has or had behavioral health challenges, and submit a copy of the organization's personnel policy that sets forth this preferred employment criteria;<br><br>(4) Employ a staff that is comprised of at least 75% individuals who are current or previous caregivers of youth with behavioral health challenges, or are individuals who have experience with State or local services and systems as a consumer who has or had emotional, behavioral health challenges, and submit a list of staff and positions held with identification of those who fit the experienced caregiver and consumer criteria; and<br><br>(5) Maintain general liability insurance.<br><br>To provide family peer support, the peer support provider shall:<br>(1) Be employed by a Family Support Organization;<br>(2) Be at least 18 years old;<br>(3) Receive supervision from an |

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| | | | individual who is at least 21 years old and has at least three years of experience providing family peer support or working with children with serious behavioral health challenges and their families;<br>(4) Have current or prior experience as a caregiver of a child with behavioral health challenges or be an individual with experience with State or local services and systems as a consumer who has or had behavioral health challenges ; and<br>(5) Receive training and certification as approved by MHA. |

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

| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
|---|---|---|
| **Family Peer Support** | Administrative Service Organization on behalf of the Mental Hygiene Administration | ASO At the time of application and at least every three years |

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

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | ☑ | Provider managed |

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Expressive and Experiential Behavioral Services**

Service Definition (Scope)*:*

Expressive and Experiential Behavioral Services are adjunct therapeutic modalities to support individualized goals as part of the plan of care. These services involve action on the part of the provider and the participant. The aim of creative therapeutic modalities is to help participants find a form of expression beyond words or traditional therapy. They include techniques that can be used for self-expression and personal growth and aid in the healing and therapeutic process.
Experiential and Expressive Therapeutic Services include the following, and may include other specific service types if they meet DHMH's standards for training, certification, and accountability:

- Art Behavioral Services
- Dance/Movement Behavioral Services
- Equine-Assisted Behavioral Services
- Horticultural Behavioral Services
- Music Behavioral Services
- Drama Behavioral Services

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

| | |
|---|---|
| | Expressive and Experiential Behavioral Service Providers must receive prior authorization from the Administrative Service Organization for these services before providing them to participants.<br><br>Participants may receive a maximum of two different expressive and experiential behavioral services on the same day. |
| ☐ | Medically needy *(specify limits):* |
| | |

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| Expressive and Experiential Behavioral Service Providers | N/A | Board Certified Therapeutic Provider per specific therapeutic discipline | Programs are approved by the Department of Health and Mental Hygiene. Licensed mental health providers are subject to all the rules and regulations in the Maryland Health Occupations Article and to the oversight of their respective licensing boards.<br><br>To provide a particular expressive and experiential behavioral service, an individual shall have:<br>(a) A bachelor's or master's degree from an accredited college or university; and<br>(b) Current registration in the applicable Certification Body.<br><br>The Department of Health and Mental Hygiene will maintain a publicly available list of Certification Bodies.<br><br>The provider organization must maintain general liability insurance. |

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

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

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

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | ☑ | Provider managed |

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

| Service Title: | **Mental Health Consultation to Health Care Professionals** |
|---|---|

Service Definition (Scope)*:*

Mental health consultation may be provided to a health care professional who is treating a participant in the HCBS benefit. Mental health consultation is a service provided by a psychiatrist, psychologist, licensed certified social worker (LCSW), licensed certified social worker-clinical (LCSW-C), licensed clinical professional counselor (LCPC), nurse psychotherapist, or psychiatric nurse practitioner for the sole purpose of offering an expert opinion or advising the treating physician or other health care professional about an individual patient with regard to the individual's mental health. It does not include (1) Decisions that direct patient care; or (2) Interpretation of images, tracings, or specimens on a regular basis. Health care professionals are individuals who are licensed in good standing under the Health Occupations Article, Annotated Code of Maryland, as a physician, psychiatrist, psychologist, licensed certified social worker (LCSW), licensed certified social worker-clinical (LCSW-C), licensed clinical professional counselor (LCPC), nurse psychotherapist or psychiatric nurse practitioner.

- Mental health consultation may be requested by a treating health care professional providing somatic care when there are questions or concerns related to medications, appropriateness of treatment modalities, or diagnoses. The consultation may occur telephonically or in-person.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

Mental health consultation may be provided on the same day as any other HCBS benefit service or Public Mental Health System service. Only the health care professional providing the consultation may bill for the service; the health care professional requesting and receiving the consultation may not bill for the time spent in consultation. There is a maximum of 24 hours of mental health consultation that may be authorized within a twelve month period for the HCBS benefit participant.

☐ Medically needy *(specify limits):*

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| Mental health consultants | Licensed under Health Occupations Article, Annotated Code of Maryland as a physician, psychiatrist, psychologist, licensed certified social worker (LCSW), licensed certified social | | Enrolled as a provider in the Maryland Medical Assistance Program and either associated with an expert consultative program approved by the Department, or listed as a primary therapist or psychiatrist on the participant's plan of care. |

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| | worker-clinical (LCSW-C), licensed clinical professional counselor (LCPC), nurse psychotherapist, or psychiatric nurse practitioner. | | |

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

| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
|---|---|---|
| **Mental health Consultation to Health Care Professionals** | Administrative Service Organization on behalf of the Mental Hygiene Administration | At the time of application and annually |

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

| | | | |
|---|---|---|---|
| ☐ | Participant-directed | ☑ | Provider managed |

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Customized Goods and Services**

Service Definition (Scope)*:*

Customized Goods and Services are those used in support of the child and family's POC for a participant receiving care coordination from a CCO. All customized goods and services expenditures must be used to support the individualized POC for the child and family and are to be used for reasonable and necessary costs. A reasonable cost is one that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. Necessary costs have been generally determined to be those that are likely to improve outcomes or remediate a particular and specific need identified in the POC.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

| | |
|---|---|
| | Unallowable costs include, but are not limited to the following:<br>1. Alcoholic Beverages;<br>2. Bad Debts;<br>3. Contributions and Donations;<br>4. Defense and prosecution of criminal and civil proceedings, claims, appeals and patent infringement;<br>5. Entertainment Costs;<br>6. Incentive compensation to employees;<br>7. Personal use by employees of organization-furnished automobiles (including transportation to and from work);<br>8. Fines and Penalties;<br>9. Goods or Services for Personal Use;<br>10. Interest on Borrowed Capital/Lines of Credit;<br>11. Costs of Organized Fundraising;<br>12. Costs of Investment Counsel/Management;<br>13. Lobbying;<br>14. Renovation/Remodeling and Capital Projects.)<br><br>Customized Goods and Services should be used as the funding source of last resort - only for those costs that cannot be covered by any other source and that are vital to the implementation of the POC. Funding shall not exceed $2,000 annually per participant. |
| ☐ | Medically needy *(specify limits):* |

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

| Provider Type *(Specify)*: | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
|---|---|---|---|
| **Providers of Customized Goods and Services** | | COMAR 10.09.45 and Wraparound Certificate Program | Enrolled as a Mental Health Case Management Provider under COMAR 10.09.45 and designated by the Department of Health and Mental Hygiene as a Care Coordination Organization under the 1915(i) HCBS Benefit.<br><br>The CCO must have a written customized goods and services policy and procedures to ensure accountability and shall comply with requirements established by DHMH. The CCO shall submit requests for customized goods and services within the bounds of the program to the Department or its designee for approval and purchase. |
| **ALL HCBS Benefit Providers** | | | **All service providers will be required to comply with the following requirements:**<br>**1)** Provide the documentation required by the Department for initial approval and provider recertification, or as |

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| | | | requested by the Department;<br>**2)** Have a provider agreement in effect, to include adherence to quality assurance, auditing, and monitoring policies and procedures;<br>**3)** Receive training and certification as required and approved by MHA and determined to be appropriate for the level and scope of services provided;<br>**4)** Meet all the conditions for participation in COMAR 10.09.36 except as otherwise specified;<br>**5)** Maintain general liability insurance, and provide proof of this insurance at the time of initial application to be a provider of HCBS benefit services, at recertification, and upon request by the Department;<br>**6)** Be included on the Plan of Care in order to bill for a service;<br>**7)** Make available to the Department and federal funding agents all records, including but not limited to personnel files for each individual employed, and financial, treatment, and service records for inspection and copying; and<br>**8)** Comply with the following prohibitions against utilization of staff:<br>**a.** Unless waived by the Department in accordance with §d below, prohibit from working with the participant or the participant's family any staff, volunteers, students, or any individual who is:<br>**i.** Convicted of, received probation before judgment, or entered a plea of nolo contendere to a felony or a crime of moral turpitude or theft; or<br>**ii.** Has an indicated finding of child abuse or neglect; and<br>**b.** Before permitting staff, volunteers, students, or any individual from working with the participant, or the participant's |

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| | | | family:<br>**i.** Ensure that, at its own expense, all staff, volunteers, students, and any individual have background checks as set forth in §§B and C of this regulation;<br>**ii.** Review the results of the background checks; and<br>**iii.** Maintain the background checks in the individual's personnel file; and<br>**c.** Maintain written documentation in the individual's personnel file that the director and all direct service provider staff including, but not limited to, volunteers, interns, and students, meet the criteria set forth in this document.<br>**i.** Required Criminal Background Checks for Provider Agencies: Each provider agency providing services to participants and their families under the HCBS Benefit shall, before providing services to participants and their families under the benefit, ensure that the individual providing services has State and Federal Bureau of Investigation child care criminal history record check report issued from Department of Public Safety and Correctional Services (DPSCS), in accordance with Family Law Article, §5-561, Annotated Code of Maryland, to the provider agency and maintained in the individual's personnel file.<br>**ii.** Required Criminal Background Checks for Expressive and Experiential Behavioral Service Providers Who Enroll as Individual Providers: For each individual that has enrolled individually to provide expressive and experiential behavioral services to participants and their families |

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| | | | in the HCBS benefit, the individual must request a State and Federal Bureau of Investigation child care criminal history record check to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services (DPSCS), in accordance with Family Law Article, §5-561, Annotated Code of Maryland, to be sent to the Department.<br>**iii.** Required Check for Abuse or Neglect: For each individual providing services to participants and their families in the HCBS benefit, the provider shall: Before employing any individual, submit a notarized Consent for Release of Information/Background Clearance Request form to the Department of Human Resources (DHR) or a local department of social services (DSS) in the jurisdiction in which the individual lives, pursuant to COMAR 07.02.07.19; and<br>**1.** Request that DHR or the local DSS send the report to:<br>**a.** The agency if the request is from a provider agency concerning the program director, staff, volunteers, or students who will work with the participant or family; or<br>**b.** To the Department, if the provider is a self-employed, independent practitioner.<br>**d.** Waiver of Employment Prohibitions.<br>**i.** The Department may waive the prohibition against working |

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| | | | with the participant or the participant's family if the provider submits a request to the Department together with the following documentation that:<br>**1.** For criminal background checks:<br>**a.** The conviction, the probation before judgment, or plea of *nolo contendere* to the felony or the crime involving moral turpitude or theft was entered more than 10 years before the date of the employment application;<br>**b.** The criminal history does not indicate behavior that is potentially harmful to participants; and<br>**c.** Includes a statement from the individual as to the reasons the prohibition should be waived; and,<br>**2.** For abuse and neglect findings:<br>**a.** The indicated finding occurred more than 7 years before the date of the clearance request;<br>**b.** The summary of the indicated finding does not indicate behavior that is potentially harmful to the participant or the participant's family; and<br>**c.** Includes a statement from the individual as to the reasons the prohibition should be waived.<br>**3.** If the Department waives the employment prohibition, the Department shall provide this information to the |

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| | | | CCO to provide to families prior to utilizing a provider.<br>The CCO providing care coordination services must ensure that all individuals and organizations on a participant's plan of care that are receiving payment for the service on the plan of care are in compliance with the criminal background check and child abuse and neglect clearance policies outlined above. |

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

| Provider Type *(Specify)*: | Entity Responsible for Verification *(Specify):* | Frequency of Verification *(Specify):* |
|---|---|---|
| **Customized Goods and Services** | Administrative Service Organization on behalf of the Mental Hygiene Administration | At the time of application and annually |

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

| | | | |
|---|---|---|---|
| ☑ | Participant-directed | ☑ | Provider managed |

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3. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; I the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participants' family members may not be reimbursed for the provision of HCBS. Family is defined as a parent, parent substitute, or legal guardian.

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# Participant-Direction of Services

*Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).*

**b. Election of Participant-Direction**. (*Select one):*

| | |
|---|---|
| ○ | The state does not offer opportunity for participant-direction of State plan HCBS. |
| ○ | Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services. |
| ● | Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):* |
| | Parents and guardians will be permitted to direct customized good and services, community and out-of-home respite care services, and select a provider of their choice subject to requirements of Maryland law. |

**2. Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

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|---|
| N/A |

**3. Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

| | |
|---|---|
| ● | Participant direction is available in all geographic areas in which State plan HCBS are available. |
| ○ | Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option*): |
| | |

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

| Participant-Directed Service | Employer Authority | Budget Authority |
|---|---|---|
| Community-based respite care | ☐ | ☑ |
| Out-of-home respite | ☐ | ☑ |
| Customized goods and services | ☐ | ☑ |

**5. Financial Management.** (*Select one):*

| | |
|---|---|
| ● | Financial Management is not furnished. Standard Medicaid payment mechanisms are used. |
| ○ | Financial Management is furnished as a Medicaid administrative activity necessary for |

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| | administration of the Medicaid State plan. |

**6.** ☑ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment, a person-centered process produces a person-centered service plan for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

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**6. Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

If a family wishes to terminate from participant directed respite care, the CFT will arrange for an agency respite provider to serve the family. The only circumstance in which a family would be involuntarily terminated from participant directed respite care or from using customized good or services would be in cases of suspected or substantiated fraud or abuse.

**7. Opportunities for Participant-Direction**

**a. Participant–Employer Authority** (individual can hire and supervise staff). (*Select one):*

| | | |
|---|---|---|
| ● | The state does not offer opportunity for participant-employer authority. | |
| ○ | Participants may elect participant-employer Authority *(Check each that applies):* | |
| | ☐ | **Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. |
| | ☐ | **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions. |

**b. Participant–Budget Authority** (individual directs a budget). (*Select one):*

| | |
|---|---|
| ○ | The state does not offer opportunity for participants to direct a budget. |
| ● | Participants may elect Participant–Budget Authority. |
| | **Participant-Directed Budget**. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan):* |
| | **The CCO will address participant direction of respite care and customized good and services with family caregivers as a part of the regular CFT meetings. The individual budget will be established as a part of the POC and will be guided by those rates established for agency delivered respite care services and the service limits that apply to those services. Need for respite care services will be based on the degree of caregiver burden and governed by the same medical necessity standards for all respite care.** |
| | **Expenditure Safeguards.** *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):* |

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| | **Each family that elects participant direction of respite care and/or customized goods and services will be subject of an expenditure review with their care coordinator at their regular CFT meetings to assure that premature depletion or underutilization of services are not an issue.** |

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# Quality Improvement Strategy

*(Describe the state's quality improvement strategy in the tables below):*

| Discovery Activities | | | | | Remediation | |
|---|---|---|---|---|---|---|
| **Requirement** | **Discovery Evidence** *(Performance Measures)* | **Discovery Activity** ***(Source of Data & sample size)*** | **Monitoring Responsibilities** *(agency or entity that conducts discovery activities)* | **Frequency** | **Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)* | **Frequency** *of Analysis and Aggregation* |
| Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers. | 1. % of participants who had a CFT meeting at least every 45 days.<br><br>2. % of participants whose plan of care (POC) was updated to include change in progress, services or other areas within five (5) days of the CFT meeting.<br><br>3. % of participants whose POC indicates they were afforded choice in the selection of services and providers | 1. Defensible sample of case files (electronic or paper) of participants who were enrolled during the time period under review<br>2. Review of all POC during identified time period for a defensible | 1. DHMH/MHA, with CSAs<br><br>2. DHMH/MHA with CSAs | 1. Every 12 months<br><br>2. Every 12 months | 1. DHMH/MHA with CSAs<br><br>2. DHMH/MHA with CSAs | If a performance improvement plan is needed, a program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to MHA, ASO, and CSA, as applicable, within 30 |

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| | 4. Utilization review of services on POC in conjunction with provider authorization and claims data | sample of participants who were enrolled during the time period under review<br><br>3. Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review<br><br>4. Review of all POC during identified time period for a defensible sample of participants | 3. DHMH/MHA with CSAs<br><br>4. ASO | 3. Every 12 months<br><br>4. Every 12 months | 3. DHMH/MHA with CSAs<br><br>4. DHMH/MHA with ASO & CSAs | working days of notice of program deficiencies. The CSA will follow up with the program 3 months after the final implementation of the performance improvement plan. |

| | | | | | | |
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| | | who were enrolled during the time period under review | | | | |
| Providers meet required qualifications . | 1.<br>1. % of providers who have submitted 1915(i) HCBS claims who are approved as providers by Maryland Medicaid<br><br>2. % of providers who meet the initial and ongoing requirements established by DHMH/MHA | 1 & 2. Defensible sampling strategy of provider files and related documentation . The sample will be drawn from providers who filed claims for services provided under the HCBS benefit during the time period under review. | 1 & 2. ASO | Annually | DHMH/MHA | If a performance improvement plan is needed, a program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to MHA within 30 working days of notice of program deficiencies. The CSA will follow up with the program 3 months after the final implementatio |

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| | | | | | | n of the performance improvement plan. |
| Settings meet the home and community-based setting requirements as specified in this SPA. | 1. % of youth who reside within approved living situations or who are disenrolled as a result of moving to a setting that is not authorized in this SPA. | 1. Semi-annual sampling of entire enrolled roster | 1. DHMH/MHA with the CSAs | Semi Annually | DHMH/MHA | Based on the findings, OHS and MHA will create a performance improvement plan within 30 working days of identification of deficiencies |
| The SMA retains authority and responsibility for program operations and oversight. | 1. % of quarterly progress reports submitted to DHMH/Office of Health Services<br><br>2. % of enrollment census updates distributed to OHS<br><br>3. Medical Eligibility/enrollment Oversight | 1. Quarterly reports are provided to OHS by MHA<br><br>2. Review of distribution list for census updates issued by MHA<br>3. Review CASII/CONS documentation | 1&2. DHMH/MHA<br><br>3. ASO/MHA | Annually | DHMH/MHA& DHMH/OHS | Based on the findings, OHS and MHA will create a performance improvement plan within 30 working days of identification of deficiencies. |
| The SMA maintains financial accountability through payment of claims for | 1. % of HCBS benefit service claims processed appropriately against fund source, authorization history, service limitations, and coding.<br><br>2. % of participants with completed financial eligibility reviews in accordance with policy at | Defensible sampling strategy; point in time review of services received. | DHMH/ASO | Annually | DHMH/MHA | If a performance improvement plan is needed, a program director must submit a |

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| services that are authorized and furnished to 1915(i) participants by qualified providers. | initial and redetermination (to include Medical Assistance eligibility and Level of Intensity documentation). | | | | | proposal within 10 working days. The final performance improvement plan must be submitted to MHA within 30 working days of notice of program deficiencies. The CSA will follow up with the program 3 months after the final implementatio n of the performance improvement plan.<br><br>The Office of Compliance is a unit within the MHA responsible for identifying fraud and abuse, educating |

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| | | | | | | providers about compliance issues, and ensuring consistency with State and federal regulations.<br><br>MHA may direct the ASO to retract paid claims, and may refer noncompliant providers to the Office of the Inspector General or Medicaid Fraud Unit with the Attorney General's Office. MHA participates with the Office of Inspector General to identify provider outliers for investigation |

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| | | | | | | of potential fraud and abuse. |
| The state identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints. | % of reportable events involving abuse, neglect, and/or exploitation reported that are resolved according to policy | All Reportable Event Forms are reviewed for compliance | DHMH/MHA | Quarterly | DHMH/MHA | If a performance improvement plan is needed, a program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to MHA within 30 working days of notice of program deficiencies. The CSA will follow up with the program 3 months after the final implementation of the performance improvement plan. |

| **System Improvement**: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)* | | | |
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| Methods for Analyzing Data and Prioritizing Need for System Improvement | Roles and Responsibilities | Frequency | Method for Evaluating Effectiveness of System Changes |
| When data analysis reveals the need for system change, recommendations will be made along with a prioritization of design changes. Plans developed as a result of this process will be shared with stakeholders. All issues related to health, welfare, and safety will be prioritized above all else. Some issues may be monitored for a period of time if they do not threaten the health, welfare, or safety of participants and do not impede the State's ability to receive federal financial participation.<br><br>Maryland will review the enrollment and disenrollment data in conjunction with HCBS benefit service utilization, inpatient psychiatric hospitalizations, psychiatric emergency room admissions, and PRTF utilization. The service utilization data will be assessed along with cost data. Additional measures of satisfaction, fidelity to Wraparound, and other process measures will be assessed as well. | DHMH, MHA, in conjunction with the ASO and the CSAs, will gather and analyze the data and identify areas for quality improvement. | Annually | Maryland will examine prior year data and examine data, to the extent it is available, on the functional outcomes of youth served through the HCBS Benefit, particularly with regard to remaining in or returning to a family-living environment, attending school or work, and not having future involvement with the juvenile justice or adult corrections systems. There will also be a focus on the comprehensive cost of care for youth enrolled in the HCBS benefit and served by the CCOs, as well as the psychotropic medication prescribing for these youth and their access to physical and oral health care services. |

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## Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

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| ☑ | HCBS Case Management |

**Mental Health Consultation to a Health Care Professional**

Mental health consultation may be provided to a health care professional who is treating a participant in the HCBS benefit. Mental health consultation is a service provided by a psychiatrist, psychologist, licensed certified social worker (LCSW), licensed certified social worker-clinical (LCSW-C), licensed clinical professional counselor (LCPC), nurse psychotherapist, or a psychiatric nurse practitioner for the sole purpose of offering an expert opinion or advising the treating physician or other somatic health care professional about an individual patient with regard to the individual's mental health.

In order to ensure consistency with Maryland regulations (COMAR 10.32.05.02), consultation is defined as a service provided for the sole purpose of offering an expert opinion or advising the treating provider about an individual patient and does not include (1) decisions that direct patient care; or (2) interpretation of images, tracings, or specimens on a regular basis. Health care professionals are individuals who are licensed in good standing under the Health Occupations Article, Annotated Code of Maryland, as a physician, psychiatrist, psychologist, licensed certified social worker (LCSW), licensed certified social worker- clinical (LCSW-C), licensed clinical professional counselor (LCPC), nurse psychotherapist, or psychiatric nurse practitioner.

Providers will bill the Department of Health and Mental Hygiene directly for mental health consultation to health care professionals. No more than one unit of service may be billed for services delivered at the same time by the same staff. The consultation may be provided in-person or telephonically. Public and private mental health consultation providers will be reimbursed at the same rate.

**RATE DEVELOPMENT** – The Mental Health Consultation rate compensates providers for the time spent providing expertise to a health care professional about a particular patient when there are questions or concerns related to medication, appropriateness of treatment modalities, or diagnoses.

The rate is the same as the rate in the fee schedule for mental health consultation in an outpatient setting for physicians and psychiatric nurse practitioners (COMAR 10.21.25.06), which may be found at http://www.dsd.state.md.us/comar/getfile.aspx?file=10.21.25.06.htm

## Customized Goods and Services

Customized Goods and Services are those used in support of the child and family's Plan of Care (POC) for a participant receiving care coordination from a Care Coordination Organization (CCO). All customized goods and services expenditures must be used to support the individualized POC for the child and family and are to be used for reasonable and necessary costs. Reasonable, defined as a cost that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. Necessary, defined as those that are likely to improve outcomes or remediate a particular and specified need identified in the POC. The CCO must have a written customized goods and services policy and procedures to ensure accountability and comply with requirements established by DHMH. The CCO shall submit requests for customized goods and services within the bounds of the program to the Department or its designee for approval and purchase.

Unallowable costs include, but are not limited to the following: Unallowable costs for customized goods and services include, but are not limited to the following:
(1) Alcoholic beverages;
(2) Bad debts;
(3) Contributions and donations;
(4) Defense and prosecution of criminal and civil proceedings, claims, appeals, and patent infringement;
(5) Entertainment costs
(6) Incentive compensation to employees;
(7) Personal use by employees of organization-furnished automobiles, including transportation to and from work;
(8) Fines and penalties;
(9) Goods or services for personal use;
(10) Interest on borrowed capital/lines of credit;
(11) Costs of organized fundraising;
(12) Costs of investment counsel/management;
(13) Lobbying; or
(14) Renovation/remodeling and capital projects

Customized Goods and Services should be used as the funding source of last resort for those costs that cannot be covered by any other source and that are vital to the implementation of the POC. Customized $2,000 per participant per State Fiscal Year for customized goods and services.

**CFT Participation**

Providers may be reimbursed for participation in a Child and Family Team (CFT) meeting. Providers will bill the Department of Health and Mental Hygiene directly for participating in the CFT meeting. No more than one unit of service may be billed for services delivered at the same time by the same staff. Private and public CFT participation providers will be reimbursed at the same rate.

The CFT meeting is critical to the Wraparound practice model that is underpinning the 1915(i) HCBS Benefit. The plan of care is created, managed, and modified at the CFT meetings, and the CFT meetings are a primary method for ensuring that all treatment plans and activities to support the youth are coordinated and integrated. Child and Family Team (CFT) Participation is the participation face-to-face (in-person) or by electronic or telephonic methods in the Child and Family Team meeting by an identified member of the CFT, according to the Plan of Care.

RATE DEVELOPMENT: The CFT Participation rate compensates providers for the time spent in the meeting. CFT meetings are between 90 minutes and two hours on average, based on our experience in Maryland, and the CFT meets at least every 45 days (the minimum, per the service description for care coordination).

There are two rates for CFT Participation: one for face-to-face participation and one for telephonic/electronic participation. Providers who participate face-to-face are reimbursed at a higher rate than those who participate telephonically or through other electronic means in recognition of the additional time spent in unbillable activities during travel to and from the CFT meeting.

The rate for face-to-face participation is based on the lowest rate provided under the 1915(i) HCBS benefit, which is the rate for non-licensed mental health practitioner expressive and experiential therapy providers. This rate was further divided in half to create a telephonic/electronic rate.

The electronic rate is for participation through electronic means such as video-conferencing or other similar technologies that enable real-time participation of the provider in the CFT meeting.

**CFT Participation Rate:**
**CFT Participation (Face-to-Face): $15.55 per 15 minutes**
**CFT Participation (Telephonic/Electronic): $7.77 per unit of service**

The unit of service is 15 minutes. There is a maximum of 8 units of service per month per provider that may be reimbursed per HCBS participant. Care coordinators may not bill for this service, and will bill for the time spent in the CFT meeting using their regular rate. It is not incorporated into the rates of any other 1915(i) HCBS providers.

☐ HCBS Homemaker

| | |
|---|---|
| ☐ | HCBS Home Health Aide |
| ☐ | HCBS Personal Care |
| ☐ | HCBS Adult Day Health |
| ☐ | HCBS Habilitation |
| ☑ | HCBS Respite Care |

**COMMUNITY-BASED RESPITE CARE**

| | Annual Amount or Rate | %FTE | Salary Cost | Fringe Benefits (30%) | Salary + Fringe Cost |
|---|---|---|---|---|---|
| Respite Supervisor | $ 50,000.00 | 0.10 | $ 5,000.00 | $ 1,500.00 | $ 6,500.00 |
| Administrative Support | $ 35,000.00 | 0.05 | $ 1,750.00 | $ 525.00 | $ 2,275.00 |
| **Total** | | 0.15 | $ 6,750.00 | $ 2,025.00 | $ 8,775.00 |
| | | | | | |
| **Other Costs (based on FTE)** | | | | | |
| Rent (144 Square Feet @ $15 per square foot per FTE) | | | | | $ 324.00 |
| Cellular Phone, Internet & Communications (@$110/month per FTE) | | | | | $ 198.00 |
| Mileage (10,000 miles per year @ $0.555/mile) | | | | | $ 5,550.00 |
| Insurance (general liability, professional liability) @$1,000 per FTE | | | | | $ 150.00 |
| Indirect Cost (7% of salaries) | | | | | $ 472.50 |
| | | | | | |
| | | | | | |
| Total cost for 1 FTE respite care worker | | | | | $ 15,469.50 |
| Hourly Rate--Not Including Respite Care Worker (Based on 1386 hours) | | | | | $ 11.16 |
| Hourly Rate for Administration + Respite Care Worker + $1 Youth Activity Fee | | | | | $ 25.16 |
| | | | | | |
| | | | | | |
| **Assumptions** | | | | | |
| 68% billable time | | | | | |
| Respite Care worker has caseload of 15 | | | | | |
| Hourly rate is added to hourly pay for respite care worker of $13/hour | | | | | |
| Additional $1 youth activity fee per hour is added to total | | | | | |

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| **OUT-OF-HOME RESPITE** | |
| **Out-of-Home Respite** | |
| Median per diem rate for 109 "preferred" programs | 181.31 |
| 10% Administrative Charge | 18.13 |
| **Total** | **199.44** |

The rate development is based on the Fiscal Year 2012 Maryland Interagency Rates Committee (IRC) rates for residential child care facilities and child placement agencies. The IRC is charged with developing and operating a rate process for residential child care and child placement agency programs that is fair, equitable and predictable, and is comprised of representatives from the Department of Budget and Management, Department of Health and Mental Hygiene Administration/Mental Hygiene Administration, Department of Human Resources/Social Services Administration, Department of Juvenile Services, Governor's Office for Children and the Maryland State Department of Education (http://www.marylandpublicschools.org/MSDE/divisions/earlyinterv/IRC).

The IRC identifies programs as "preferred" or "non-preferred." For this rate development, only preferred provider rates were incorporated. Additionally, only the per diem rates for group homes, therapeutic group homes, and treatment foster care providers were included.

The fiscal model identified in the August 2006 Real Choice Systems Change Grants for Community Living: A Feasibility Study to Consider Respite Services for Children with Disabilities in Maryland prepared by The Hilltop Institute (formerly the Center for Health Program Development and Management) at UMBC included a 10% administrative cost for training, family support, outreach and provider recruitment that was specific to the youth at the highest levels of care. A similar finding of a need for additional administrative funds was identified by the Respite Care Committee under the Maryland Blueprint for Children's Mental Health Committee.

For Individuals with Chronic Mental Illness, the following services:

| | |
|---|---|
| ☐ | HCBS Day Treatment or Other Partial Hospitalization Services |
| | |
| ☑ | HCBS Psychosocial Rehabilitation |
| | Intensive In-Home Services |

**INTENSIVE IN-HOME SERVICES (IIHS)--EBP**

| Personnel | Annual Amount or Rate | %FTE | Salary Cost | Fringe Benefits (25%) |
|---|---|---|---|---|
| Therapist | $ 50,000 | 1 | $ 50,000 | $ 12,500 |
| Supervisor/Clinical Lead | $ 75,000 | 0.20 | $ 15,000 | $ 3,750 |
| Clinical Director | $ 100,000 | 0.09 | $ 9,000 | $ 2,250 |
| Quality Assurance/Management Information Systems Director | $ 90,000 | 0.09 | $ 8,100 | $ 2,025 |
| Administrative Assistant | $ 35,000 | 0.25 | $ 8,750 | $ 2,188 |
| Billing Support Specialist | $ 35,000 | 0.05 | $ 1,750 | $ 438 |
| *Total* | | 1.68 | $ 92,600 | $ 23,150 |

**Other Costs**

Rent ($15/sq ft, 144 sq ft per FTE)
Cellular Phone, Internet & Communications (@$110/month per FTE)
Office supplies and maintenance (paper, postage, pens, printing, copier/fax) @ $750 per FTE
Mileage (20,000 miles per year @ $0.555/mile)
Management Information System @$150 per FTE
Insurance (general liability, professional liability) @ $1,000 per FTE
Indirect Cost (7% of salaries)
Total Cost for 1 FTE Therapist
**Weekly rate (Total Cost/52 weeks/11 clients)**
**Caseload of 11 clients for 16 weeks**

**Assumptions:**
Caseload of 11 clients
Supervisor caseload of 5 therapists
Maximum length of service is 16 weeks

Intensive In-Home Services (IIHS) providers may be reimbursed at a regular weekly rate of service. The approved IIHS providers will bill the Department of Health and Mental Hygiene directly for the services rendered. No more than one unit of service may be billed for services delivered at the same time by the same staff. Private and public IIHS providers will be reimbursed at the same rate.

The rate development adheres to the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current IIHS program. Cost estimates conform to our experience with programs similar to IIHS in Maryland, including the salaries paid.

An IIHS provider may bill for a week only if an IIHS activity occurred for the covered youth on at least one day of the billable week. A minimum of one (1) face-to-face contact is required per week. At least fifty percent (50%) of therapist's contacts with the youth and/or family must be face-to-face. A minimum of fifty percent (50%) of the therapist's time must be spent working outside the agency and in the youth's home or community, as documented in the case notes. An individual can only receive IIHS services from one provider at a time. Partial hospitalization/day treatment, mobile crisis response services (MCRS), and other family therapies cannot be charged at the same time. IIHS providers are expected to provide crisis response services for the youth on their caseload.

An evidence-based practice (EBP) is defined as a program, intervention or service that:

1. is recognized by DHMH as an EBP for youth;
2. has standardized and replicable clinical or rehabilitative interventions that:
   a. are derived from rigorous, scientifically controlled research; and
   b. can be applied in community settings with a defined clinical population;
3. has a consistent training and service delivery model;
4. utilizes a treatment manual; and
5. has demonstrated evidence that successful program implementation results in improved, measurable outcomes for recipients of the service intervention.

The rate for the IIHS-EBP (and, in particular, the caseload used) was based on Functional Family Therapy, an established EBP in Maryland. The rate is higher for those programs that are identified as an EBP, in keeping with the established practice of different reimbursement rates for an EBP versus non-EBP service (e.g., Mobile Treatment Services and Assertive Community Treatment).

The weekly rate for the IIHS-EBP program is based on the cost of a therapist with a maximum caseload of 11 and a maximum length of stay in the program of 16 weeks. The supervisor caseload is a ratio of 1:5. The rate includes other costs, including mileage costs (at least 50% of face-to-face contacts must be in the home or community, and the therapist must see the youth and family face-to-face at least once each week), rent, and communications costs.

**INTENSIVE IN-HOME SERVICES (IIHS)--NON EBP**

| Personnel | Annual Amount or Rate | %FTE | Salary Cost | Fringe Benefits (25%) | Salary + Fringe Cost |
|---|---|---|---|---|---|
| Therapist | $ 50,000 | 0.50 | $ 25,000 | $ 6,250 | $ 31,250.00 |
| Supervisor/Clinical Lead | $ 75,000 | 0.20 | $ 15,000 | $ 3,750 | $ 18,750.00 |
| In-Home Stabilizer | $ 40,000 | 0.50 | $ 20,000 | $ 5,000 | $ 25,000.00 |
| Clinical Director | $ 100,000 | 0.08 | $ 8,000 | $ 2,000 | $ 10,000.00 |
| Administrative Assistant | $ 35,000 | 0.25 | $ 8,750 | $ 2,188 | $ 10,937.50 |
| Billing Support Specialist | $ 35,000 | 0.05 | $ 1,750 | $ 438 | $ 2,187.50 |
| *Total* | | 1.58 | $ 78,500 | $ 19,625 | $ 98,125 |

| Other Costs | |
|---|---|
| Rent ($15/sq ft, 144 sq ft per FTE) | $ 3,412.80 |
| Cellular Phone, Internet & Communications (@$110/month per FTE) | $ 2,085.60 |
| Office supplies and maintenance (paper, postage, pens, printing, copier/fax) @ $750 per FTE | $ 1,185.00 |
| Mileage (20,000 miles per year @ $0.555/mile) | $ 11,100.00 |
| Management Information System @$150 per FTE | $ 237.00 |
| Insurance (general liability, professional liability) @$1,000 per FTE | $ 1,580.00 |
| Indirect Cost (7% of salaries) | $ 5,495.00 |
| **Total Cost FTE** | **$ 123,220.40** |
| **Weekly rate (total cost/(52*12))** | **$ 197.47** |

**Assumptions:**
Caseload of 12 clients
Supervisor caseload of 5 therapists
Youth may stay in for a year
12 clients are supported by .5 FTE therapist, .5FTE in-home stabilizer, .2 supervisor/clinical lead, and .08 clinical director

Intensive In-Home Services (IIHS) providers may be reimbursed at a regular weekly rate of service. The approved IIHS providers will bill the Department of Health and Mental Hygiene directly for the services rendered. No more than one unit of service may be billed for services delivered at the same time by the same staff. Private and public IIHS providers will be reimbursed at the same rate.

The rate development adheres to the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current IIHS program. Cost estimates conform to our experience with programs similar to IIHS in Maryland, including the salaries paid.

An IIHS provider may bill for a week only if an IIHS activity occurred for the covered youth on at least one day of the billable week. A minimum of one (1) face-to-face contact is required per week. At least fifty percent (50%) of therapist's contacts with the youth and/or family must be face-to-face. A minimum of fifty percent (50%) of the therapist's time must be spent working outside the agency and in the youth's home or community, as documented in the case notes. An individual can only receive IIHS services from one provider at a time. Partial hospitalization/day treatment, mobile crisis response services (MCRS), and other family therapies cannot be charged at the same time. IIHS providers are expected to provide crisis response services for the youth on their caseload.

The weekly rate for the IIHS program is based on the cost of a therapist (.5 FTE) and in-home stabilizer (.5 FTE) with a shared caseload of 1:12. An in-home stabilizer provides some of the face-to-face services. The supervisor caseload is a ratio of 1:5. The rate includes other costs, such as rent, communications (phone, internet), and mileage.

Mobile Crisis Response Services

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**MOBILE CRISIS & STABILIZATION SERVICES (MCRS)**

| | Annual Amount or Rate | %FTE | Salary Cost | Fringe Benefits (30%) | Salary + Fringe Cost |
|---|---|---|---|---|---|
| Crisis Responder | $ 50,000.00 | 0.75 | $ 37,500.00 | $ 11,250.00 | $ 48,750.00 |
| Clinical Supervisor | $ 65,000.00 | 0.17 | $ 10,833.33 | $ 3,250.00 | $ 14,083.33 |
| Crisis Stabilizer | $ 35,000.00 | 0.25 | $ 8,750.00 | $ 2,625.00 | $ 11,375.00 |
| Administrative Support | $ 35,000.00 | 0.17 | $ 5,833.33 | $ 1,750.00 | $ 7,583.33 |
| Clinical Director | $100,000.00 | 0.06 | $ 6,250.00 | $ 1,875.00 | $ 8,125.00 |
| **Total** | | 1.40 | $ 69,166.67 | $ 20,750.00 | $ 89,916.67 |

**Other Costs (based on FTE)**

| | |
|---|---|
| Rent (144 Square Feet @ $15 per square foot per FTE) | $ 3,015.00 |
| Cellular Phone, Internet & Communications (@$110/month per FTE) | $ 1,842.50 |
| Mileage (10,000 miles per year @ $0.555/mile) | $ 5,550.00 |
| Insurance (general liability, professional liability) @$1,000 per FTE | $ 1,395.83 |
| Indirect Cost (7% of salaries) | $ 4,841.67 |

| | |
|---|---|
| Total cost for 1 FTE crisis responder/stabilizer | $ 106,561.67 |
| Hourly rate | $ 102.46 |
| 30 minute rate | $ 51.23 |
| 15 minute rate | **$ 25.62** |
| **Assessment Rate: 3 hours** | **$ 307.39** |

**Assumptions:**

50% time billable, assuming non-face to face crisis response and stabilization (e.g., crisis call, documentation, etc) is billable based on input from Milwaukee's Urgent Treatment Team experience

Clinical supervisor oversees 6 crisis responders and 2 crisis stabilizers.

Mobile Crisis Response and Stabilization (MCRS) providers may be reimbursed at a 15 minute service interval. There is also a single assessment rate for the development of the initial crisis plan with the care coordinator and family at the beginning of services under the 1915(i) HCBS benefit. The approved MCRS providers will bill the Department of Health and Mental Hygiene directly for the services rendered. No more than one unit of service may be billed for services delivered at the same time by the same staff. Private and public MCRS providers will be reimbursed at the same rate.

The rate development adheres to the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in similar non-office based programs. (Salaries are assumed based on the credentials for the personnel and the salaries paid to similar individuals in other programs.)

The design of MCRS was based in part on the Mobile Urgent Treatment Team (MUTT) in Milwaukee, which is a part of Wraparound Milwaukee. MUTT has identified that approximately 50% of a MUTT clinician's time is spent in face-to-face clinical care, with the remaining time spent in travel, documentation, and non-face to face activities. For every crisis responder that is employed, there needs to be a percentage of a clinical supervisor and a crisis stabilizer to ensure that the crisis calls are appropriately triaged and the necessary level of clinical expertise is available.

Expressive and Experiential Behavioral Services

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**Expressive & Experiential Behavioral Services**

**Proposed Rates**

| | | |
|---|---|---|
| Expressive Therapies--Individual, LMHP | 45-50 minutes | $68.41 |
| Expressive Therapies--Individual, LMHP | 75-80 minutes | $89.62 |
| Expressive Therapies--Individual, non LMHP | 45-50 minutes | $62.19 |
| Expressive Therapies--Individual, non LMHP | 75-80 minutes | $80.85 |
| Expressive Therapies--Group, LMHP | 45-60 minutes | $24.16 |
| Expressive Therapies--Group, LMHP | Prolonged (75-90 minutes) | $31.41 |
| Expressive Therapies--Group, non LMHP | 45-60 minutes | $27.20 |
| Expressive Therapies--Group, non LMHP | Prolonged (75-90 minutes) | $35.36 |

*LMHP=Licensed Mental Health Practitioner*

**Rates from FY13 PMHS:**

| | |
|---|---|
| 45-50 minute rate for an individual clinician in the PMHS, FY 13 | 62.19 |
| 75-80 minute rate for C&A Prolonged Psychotherapy | 80.85 |
| 45-60 minute rate for C&A group psychotherapy | 27.2 |
| Prolonged rate for C&A Group Psychotherapy | 35.36 |

The approved expressive & experiential behavioral therapy providers will bill the Department of Health and Mental Hygiene directly for the services rendered. No more than one unit of service may be billed for services delivered at the same time by the same staff.

Rate development: The following details the rate development for expressive and experiential behavioral therapy services. Expressive and Experiential Behavioral Therapy Services Providers must have a) A bachelor's or master's degree from an accredited college or university; and (b) Current registration in the applicable association. The applicable registrations and associations include the following:

- Registered art therapist by the Art Therapy Credentials Board in the American Art Therapy Association;
- Dance Therapist Registered or Academy of Dance Therapists Registered in The American Dance Therapy Association
- Certified by The Equine Assisted Growth and Learning Association (EAGALA) to provide services under the EAGALA model
- Horticultural Therapist Registered by The American Horticultural Therapy Association
- Music Therapist-Board Certified by the Board for Music Therapists, Inc in the American Association for Music Therapy, Inc.
- Registered Drama Therapist or Board Certified Trainer in the National Association for Drama Therapy

These associations, registrations and certifications were identified as having comprehensive standards, continuing education requirements, and examinations. As such, the rate for this service has been aligned with the Medicaid rate for individual practitioners (licensed certified social worker-clinical, nurse psychotherapist, licensed clinical professional counselor, licensed clinical marriage and family therapist, and certified registered nurse practitioner-psychiatric) for 45-50 minutes of individual therapy with a child or adolescent ($62.19/hour). These rates were set by the State of Maryland at approximately 70% of the Medicare rate for individual therapy provided by practitioners of a similar skill level.

Expressive and experiential behavioral therapy service providers who are licensed mental health professionals (licensed certified social worker-clinical, nurse psychotherapist, licensed clinical professional counselor, licensed clinical marriage and family therapist, and certified registered nurse practitioner-psychiatric) are reimbursed for this service at a rate that is 10% greater than the standard rate for non-mental health licensed professionals providing the same service. A differential was selected based on the additional costs to providers to obtain and maintain their license and the cost of and time required to obtain continuing education credits. In the 1915(c) PRTF Demonstration Waiver (RTC Waiver), it was difficult to 1) ascertain how many of the expressive and experiential behavioral service providers were also licensed mental health clinicians and 2) encourage licensed mental health clinicians who were already Public Mental Health System providers to enroll to provide the additional service (a necessary step in helping families and youth to identify the most appropriate provider to address their needs). As a result, the higher rate was developed to address both of these issues through a mechanism to encourage provider enrollment and more accurately track provider utilization.

The group rates were set based on the C&A Group Psychotherapy Rates.

Family Peer Support

PEER SUPPORT

| Personnel | Annual Amount or Rate | %FTE | Salary Cost | Fringe Benefits (25%) | Salary + Fringe Cost |
|---|---|---|---|---|---|
| Family Support Partner | $ 36,000 | 1 | $ 36,000 | $ 9,000 | $ 45,000.00 |
| Family Support Partner Supervisor | $ 58,500 | 0.10 | $ 5,850 | $ 1,463 | $ 7,312.50 |
| Administrative Assistant | $ 35,000 | 0.25 | $ 8,750 | $ 2,188 | $ 10,937.50 |
| Billing Support Specialist | $ 35,000 | 0.05 | $ 1,750 | $ 438 | $ 2,187.50 |
| Administrator | $ 55,000 | 0.05 | $ 2,750 | $ 688 | $ 3,437.50 |
| *Total* | | 1.45 | $ 55,100 | $ 13,775 | $ 68,875.00 |

| Other Costs | |
|---|---|
| Rent ($15/sq ft, 144 sq ft per FTEs) | $ 3,132.00 |
| Cellular Phone, Internet & Communications (@$110/month per FTE) | $ 1,914.00 |
| Mileage (10,500 miles per year @ $0.555/mile) | $ 5,827.50 |
| Office supplies and maintenance (incl printing, copier/fax) @ $750 per FTE | $ 1,088 |
| Management Information System User Fees (@$150/FTE) | $ 218 |
| Insurance (general liability, professional liability) @ $1,000 per FTE | $ 1,450 |
| Indirect Cost (7% of salaries) | $ 3,857 |
| **Total Cost FTE** | **$ 86,360.50** |
| | |
| **Hourly rate** | **$ 63.88** |
| **30 minute rate** | **$ 31.94** |
| **15 minute rate** | **$ 15.97** |
| **15 minute telephonic/non-face-to-face rate** | **$ 7.98** |

The rate development adheres to the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current peer support programs. Cost estimates conform to our experience with peer support in Maryland.

The 15-minute rate was calculated as the cost for one family support partner for 12 months divided by 1,352 billable service hours. This was based on the amount of time that is spent traveling (without the family present), completing documentation, participating in training (including the Wraparound Practitioners Certificate Program), and leave time. Indirect costs were calculated at the standard 10% of salaries.

Peer to peer support may be provided on the same day as-Child and Family Team Participation.

The telphonic rate is established at 50% of the regular rate.

☐ HCBS Clinic Services (whether or not furnished in a facility for CMI)

☐ Other Services (specify below)

Groups Covered
Optional Groups other than the Medically needy

☑ In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. (select at least one):

☑ The state covers all of the individuals described in item 1(a) and (b) as described below. Complete 1(a) and 1(b):

1(a). ☑ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

Income Standard ☑ 150% FPL

Methodology used (Select one)

☐ SSI
☐ OTHER (describe):

DRAFT

For states that have elected the SSI methodology, the state uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (specify):

1(b). ☑ Individuals who are eligible for home and community-based services under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. For individuals eligible for 1915(c), (d) or (e) waiver services, this amount must be the same amount as the income standard specified under your state plan for the special income level group. For individuals eligible for 1915(c) like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals using institutional rules. (Select one):

☑ 300% of the SSI/FBR
☐ (Specify) _____% Less than 300% of the SSI/FBR

The state uses the same eligibility criteria that it uses for the special income level group.

☐ The state covers only the following group individuals described below. Complete 1(a) or 1(b):

1(a). ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

Income Standard ☐ 150% FPL

Methodology used (Select one)

☐ SSI
☐ OTHER (describe):

DRAFT

For states that have elected the SSI methodology, the state uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (specify):

1(b). ☐ Individuals who are eligible for home and community-based services under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. For individuals eligible for 1915(c), (d) or (e) waiver services, this amount must be the same amount as the income standard specified under your state plan for the special income level group. For individuals eligible for 1915(c) like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals using institutional rules. (Select one):

☐ 300% of the SSI/FBR
☐ (Specify) _____% Less than 300% of the SSI/FBR

The state uses the same eligibility criteria that it uses for the special income level group.

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