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State/Territory Name: Maryland

State Plan Amendment (SPA) #: 16-0007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations
SWIFT # 101920164079

December 1, 2016

Shannon McMahon, Deputy Secretary
Health Care Financing
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Ms. McMahon:

Enclosed is a copy of the approved State Plan Amendment (SPA), Transmittal Number 16-0007. This SPA updates Maryland's State Plan to clean-up inconsistencies between the State Plan and regulations, as well as fix broken website links caused during Maryland's website migration.

The effective date for this amendment is July 1, 2016. The CMS 179 form and the Approved State Plan pages are attached.

If you have questions about this SPA, please contact Lieutenant Commander Andrea Cunningham of my staff at 215-861-4325.

Sincerely,
/S/

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 16-0007

2. STATE: Maryland

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
N/A

7. FEDERAL BUDGET IMPACT:
a. FFY 2016: $ 0
b. FFY 2017: $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Att. 3.1A Page 9A & 9B (AMEND)~~
Att. 3.1A Page 19-1 & 19-1A (AMEND)
Att. 3.1A Page 29C-A (AMEND)
Att. 4.19A Page 4a (AMEND)
~~Att. 4.19B page 2 of 3 (AMEND)~~
Att. 4.19B page 18 (AMEND)
Att. 4.19B pgs 4a, 13-16a,18-23, 28, 32-B-33, 36-37-A, 38-B – 39, 41A, 51, 55-56, 58, 60, 61, 63, 65, 67 (AMEND)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Att. 3.1A Page 9A & 9B~~
Att. 3.1A Page 19-1 & 19-1A
Att. 3.1A Page 29C-A
Att. 4.19A Page 4a
~~Att. 4.19B page 2 of 3~~
Att. 4.19B page 18
Att. 4.19B pgs 4a, 13-16a,18-23, 28, 32-B-33, 36-37-A, 38-B – 39, 41A, 51, 55-56, 58, 60, 61, 63, 65, 67

10. SUBJECT OF AMENDMENT: To clean-up reimbursement links and clarify services to align with regulations.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Susan J. Tucker, Executive Director
Office of Health Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/S/

13. TYPED NAME: Shannon McMahon

14. TITLE: Deputy Secretary,
Office of Health Care Financing

15. DATE SUBMITTED: 9/16/16

16. RETURN TO:
Susan J. Tucker, Executive Director
OHS – DHMH
201 W. Preston St., 1st floor
Baltimore, MD 21201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/16/16

18. DATE APPROVED: December 1, 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
FRANCIS T. MCCULLOUGH

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR, DMCHO

23. REMARKS:
Per the request of Medicaid Officials, Pen and Ink Changes made to boxes 8 & 9 to reflect correct state plan pages being amended.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

6. Medical care and any other type of remedial care under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.

d. Nutritionist

A. The Nutrition Therapy Program covers medically necessary counseling and education services to nutritionally high-risk children under the age of 21 years and pregnant women of all ages. The services are provided by appropriately qualified staff as described below. Services must be directly related to a written treatment plan.

B. Nutrition services covered by Maryland Medicaid include:

(1) Assessment – Making a nutritional assessment of individual food practices and nutritional status using anthropometric, biochemical, clinical, dietary, and demographic data;
(2) Developing an individualized plan that establishes priorities, goals, and objectives for meeting nutrient needs for child; and
(3) Nutrition counseling and education to achieve care plan goals and includes strategies to educate client, family, caregivers, or others in carrying out appropriate interventions.

C. Nutritionist and dietitians shall be licensed by the Maryland State Board of Dietetic Practice, as defined in Health Occupations Article, Title 5, Annotated Code of Maryland, or by the appropriate licensing body in the jurisdiction where the nutrition counseling services are performed.

D. The Maryland Medicaid Nutrition Services Program does not cover:

(1) Services for non-pregnant adults ages 21 and over;
(2) More than one visit per day; and
(3) Services provided by a school health-related services provider that are not included on a child's IEP or IFSP.

DELETE PAGE

G. A residential treatment center admits patients between the ages of 12 and 21. The Department reimburses a residential treatment center, except an in-state children's residential treatment center, the lesser of, the provider's usual and customary charge unless the service is free to individuals not covered by Medicaid, the provider's per diem cost for covered services established in accordance with Medicare principles of reasonable cost reimbursement as described in 42 CFR 413 or $300 per day effective October 1, 2009. The $300 per day will be updated annually by the Centers for Medicare and Medicaid Service's published federal fiscal year market basket increase percentage relating to hospitals excluded from the prospective payment system.

1. Qualified non-facility individual practitioners may be directly reimbursed for somatic, dental, or other medically necessary services not included in the per diem rate which are provided to children in a residential treatment center.

2. Such reimbursement is subject to the payment methodologies that are otherwise specified in the State Plan.

H. Children's residential treatment center: A children's residential treatment center is a residential treatment center that admits patients 12 years of age and under. An in-state children's residential treatment center shall be reimbursed the lesser of: (1) the provider's usual and customary charge unless the service is free to individuals not covered by Medicaid or (2) the provider's per diem cost for covered services established in accordance with Medicare principles of reasonable cost as described in 42 CFR 413, or $600 per day effective December 1, 2009. The $600 per day will be updated annually by the Centers for Medicare and Medicaid Services' published federal fiscal year market basket increase percentage relating to hospitals excluded from the prospective payment system.

1. Qualified non-facility individual practitioners may be directly reimbursed for somatic, dental, or other medically necessary services not included in the per diem rate which are provided to children in a residential treatment center.

2. Such reimbursement is subject to the payment methodologies that are otherwise specified in the State Plan.

State of Maryland

Nutritionist Rates

12.a. The Agency's rates for professional services rendered by a nutritionist were set as of 7/1/2010 and are effective for services on or after that date. All nutritionist must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The nutritionist will be paid the lower of the nutritionist's customary charge to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.

12.b. All nutritionists, both government and non-government, are reimbursed pursuant to the same fee schedule. Nutritionists are paid by CPT codes which are based on a percentage of Medicare reimbursement. All rates are published to the Agency's website at: http://www.dhmh.maryland.gov/providerinfo

12.c. The Agency reimburses schools for nutritional assessments and interventions and nutritional reassessments and interventions when required under an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) and when provided by nutritionists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental community-based licensed nutritionists as described in 12.b.

12.d. Payment limitations:

- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
  - Completion of forms and reports;
  - Broken or missed appointments;
  - Professional services rendered by mail or telephone; and
  - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

C. Diagnostic Services Environmental Lead Investigations

Covered Services:

1. The service includes one on-site environmental lead inspection per primary dwelling.

2. The service is limited to Medicaid enrollees under age 21 with confirmed elevated blood lead levels of $5 \geq \mu g/dL$.

Limitations:

Provider limitations: Investigations shall be performed by Lead Risk Assessors who are accredited by the Maryland Department of the Environment with enforcement authority to ensure that lead risks are abated.

OVERHEAD

Rent/Utilities –	$ 34.20
Accounting, Audits and IT Support (5% of total salary and fringe)	$ 11.98
Telephone charges –	$ 14.40
Total Overhead/Case	$ 60.58
EQUIPMENT AND OVERHEAD TOTAL	$ 93.63

TIME, SALARY & FRINGE TOTAL	$239.66
EQUIPMENT AND OVERHEAD TOTAL	$ 93.63
TOTAL COST PER ENVIRONMENTAL INSPECTION	$333.29

1. Effective July 1, 2009, the service will be covered using the provide code T1029 – On-site Environmental Lead Inspection, per primary dwelling – at a rate of $333.29. Subsequently, the rate will increase by 2% annually. This rate can be found on the Department of Health and Mental Hygiene's website at: http://dhmh.maryland.gov/providerinfo

2. Payment is limited to providers' that are Lead Risk Assessors accredited by the Maryland, Department of the Environment with enforcement authority to ensure that lead risks are abated.

3. The Department will conduct post-payment audits to ensure that providers are not paid for testing environmental substances such as water or soil and only pays:
   - Once for each dwelling; and
   - Only when the child in the dwelling has a blood lead elevation ≥ 5 µg/dL

STATE PLAN UNDER TITLE XIXI OF THE SOCIAL SECRITY ACT

State of Maryland

10. **Dentist Rates**

10.a The Agency's rates for professional services rendered by a dentist and outlined per Attachment 3.1, page 23, were set as of 1/1/15 and effective for services on or after that date. All dentists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The dentist will be paid the lower of the dentist's customary fee schedule to the general public unless it is free to individuals not covered by Medicaid or the published fee schedule.

10.b. All dentists, both government and non-government, are reimbursed pursuant to the same fee schedule. Dentists are paid by CDT codes. Effective as of 1/1/2015, all rates are published on the Agency's website at: http://dhmh.maryland.gov/providerinfo

10.c. Payment limitations:

- The Department will not pay for drugs administered by dentists that have been obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill for the Program or the recipient for:
    - Completion of forms and reports;
    - Broken or missed appointments;
    - Professional services rendered by mail or telephone; and
    - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Optometrist Rates

11.a The Agency's rates for professional services rendered by an optometrist were set as of 7/1/10 and are effective for services on or after that date. All optometrists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The optometrist will be paid the lower of the optometrist's customary fee schedule unless it is free to individuals not covered by Medicaid or the published fee schedule.

11.b All optometrists, both government and non-government, are reimbursed pursuant to the same fee schedule. Optometrists are paid based on a percentage of Medicare reimbursement. All rates are published on the Agency's website at: http://dhmh.maryland.gov/providerinfo

11.c Payment limitations:

- The Department will not pay for practitioner-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included in the office visit.
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
    - Completion of forms and reports;
    - Broken or missed appointments;
    - Professional services rendered by mail or telephone;
    - Providing a copy of a recipient's medical record

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

4. Reimbursement Methodology for Mental Health Case Management

4.a Effective September 1, 2009, payments shall be made with the fee-for-service schedule for mental health case management services specified in 4c. This rate can be found on the Mental Health Administration's website at: http://dhmh.maryland.gov/providerinfo
Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers.

4.b "Unit of service" means a face-to-face contact for a minimum of one hour per day by the community support specialist of the community support specialist associate with the participant or, if the participant is a minor, the minor's parent or guardian. Mental health case management services are only performed by providers that meet the criteria outlined per Attachment 3.1A, Section E. Services shall be provided according to the following:

a. Level 1 – General: A minimum of one and a maximum of two units of service each month. At a minimum, every 90 days, one service shall include a visit to the participant's home or another suitable site for a participant who is homeless.
b. Level II – Intensive: A minimum of two and a maximum of five units of service each month. At a minimum, every 90 days, one service shall include a visit to the participant's home or another suitable site for a participant who is homeless.
c. One additional unit of service above the monthly maximum may be billed during the first month of service to a participant in order to complete the comprehensive assessment.

4c. Rate development – The rate for this service follows the CMS-accepted Methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on the average of the mileage of current case management providers who are receiving state general funds for case management.

4d. Case management services shall not be reimbursed for individuals in public institutions, IMDs, juvenile detention centers or PTRFs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

4. Reimbursement Methodology for Mental Health Case Management: Care Coordination for Children

4a. Effective, October 1, 2014, payment shall be made with the fee-for-service schedule mental health care management services specified in 4c. This rate can be found on the Mental Hygiene Administration's website at: http://dhmh.maryland.gov/providerinfo Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers.

4b. "Unit of service" means 15 minutes of contact, which may include face-to-face and non-face-to-face contacts with the participant, or if the participant is a minor, the minor's parent or guardian, and indirect collateral contact on behalf of the participant with other community providers. Services shall be provided according to the following:

1) Level 1 – General Coordination allows a maximum of 12 units of service per month with a minimum of two units of face-to-face contact.
2) Level II – Moderate Care Coordination allows a maximum of 30 units of service per month, with a minimum of four units of face-to-face contact.
3) Level III – Intensive Care Coordination allows a maximum of 60 units of service per month, with a minimum of six units of face-to-face contact.
4) For Level I and Level II four additional units of service above and beyond the monthly maximum may be billed during the first month of service to the participant and every six months thereafter to allow for comprehensive assessment and reassessment of the participant.
5) A unit of service for telephonic contact may not be reimbursed unless the provider has delivered at least eight minutes of service.

4c. Rate development – The rate was for the mental health case management care coordination for children and youth was developed following CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs.

4d. Reimbursement shall not be made for care coordination services if the participant is receiving a comparable care coordination service under another Program authority; the direct delivery of an underlying medical, educational, social, or other service to which a participant has been referred; activities integral to the administration of foster care programs; activities not consistent with the definition of case management services under Section 6052 of the federal Deficit Reduction Act of 2005 (P.L. 109-171); activities for which third parties are liable to pay; and activities delivered as part of institutional discharge planning. A participant's care coordinator may not be the participant's family member or a direct service provider for the participant.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Mental Health Case Management

The agency's rates for Mental Health Case Management were set as of July 1, 2013 and are effective for services on or after that date. Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both governmental and private providers. All rates for Maryland's Public Mental Health System are published on the Maryland Department of Mental Hygiene's website at the following link: http://dhmh.maryland.gov/providerinfo

Reimbursement Methodology for HIV Targeted Case Management Services

1. Effective for services on or after February 1, 2012, HIV targeted case management, including diagnostic evaluation services (DES) and ongoing case management services are paid as outlined in MD fee-for-service schedule. Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both government and nongovernmental and private individual practitioners. Fee schedule and any annual/periodic adjustments to the fee schedule are published on MD website at the following web address: http://dhmh.maryland.gov/providerinfo

2. HIV targeted case management services rendered shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene, and as outlined in the MD State Plan, Supplement 3 to Attachment 3.1A, page 4. Payment requests which are not properly prepared or submitted may not be processed, but will be returned unpaid to the provider.

3. A Diagnostic Evaluation Services (DES) "unit of service" is the completion of the bio-psychosocial assessment and plan of care including signatures of all members involved. Reimbursement is paid using a flat rate to the DES provider for completion of the bio-psychosocial assessment and plan of care.

4. An Ongoing Case Management "unit of service" is a 15-minute period in which ongoing case management services were provided. An ongoing case manager participating in the DES process, when not a representative of the DES provider, may be bill up to six units for his or her involvement in the DES process. Ongoing case management, as prescribed in the plan of care, shall be reimbursed up to 96 units of service per year following the date of service for diagnostic evaluation services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Occupational Therapist Rates

13.a The Agency's rates for professional services rendered by an occupational therapist were set as of 7/1/10 and are effective for services on or after that date. All occupational therapists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The occupational therapist will be paid the lower of the occupational therapist's customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.

13.b All occupational therapists, both government and non-government, are reimbursed pursuant to the same fee schedule. Occupational therapists are paid by CPT codes which are based on a percentage of Medicare reimbursement. All rates are published on the Agency's website at: http://dhmh.maryland.gov/providerinfo

13c. The Agency reimburses schools for occupational therapy evaluations and re-evaluations, individual occupational therapy sessions, and group occupational therapy when required under an Individualized Education Program (IEP) or Individual Family Services Plan (IFSP) and when provided by occupational therapists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental community-based licensed occupational therapists as described in 13.b.

13.d Payment limitations:

- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
  - Completion of forms and reports;
  - Broken or missed appointments;
  - Professional services rendered by mail or telephone; and
  - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of the recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Speech Therapist Rates

14.a The Agency's rates for professional services rendered by a speech-language pathologist were set as of 7/1/10 and are effective for dates of services on or after that date. All speech-language pathologists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The speech-language pathologist will be paid the lower of the speech-language pathologist's customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.

14.b All speech-language pathologists, both government and nongovernment, are reimbursed pursuant to the same fee schedule. Speech-language pathologists are paid by CPT codes which are based on a percentage of Medicare reimbursement. All rates are published on the Agency's website at: http://dhmh.maryland.gov/providerinfo

14.c The Agency reimburses schools for speech/hearing evaluation, individual speech therapy, and group speech therapy when required under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and when provided by speech-language pathologists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental community-based speech-language pathologists as described in 14b.

14.d Payment limitations:

- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
  - Completion of forms and reports;
  - Broken or missed appointments;
  - Professional services rendered by mail or telephone; and
  - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Audiologist Rates

15.a The Agency's rates for professional services rendered by an audiologist were set as of 7/1/10 and are effective for dates of services on or after that date. All audiologists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The audiologist will be paid the lower of the audiologists customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.

15.b All audiologists, both government and nongovernment, are reimbursed pursuant to the same fee schedule. Audiologists are paid by CPT codes which are based on a percentage of Medicare reimbursement. All rates are published on the Agency's website at: http://dhmh.maryland.gov/providerinfo

15.c The Agency reimburses schools for audiology evaluations when required under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and when provided by audiologists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental community-based audiologists as described in 15b.

15.d Payment limitations:

- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
  - Completion of forms and reports;
  - Broken or missed appointments;
  - Professional services rendered by mail or telephone; and
  - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

16. Therapeutic Behavioral Aide Rates

16.a The Agency's rates for one-on-one therapeutic behavioral aide services performed by therapeutic behavioral aides were set as of 1/1/10 and are effective for services on or after that date. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The therapeutic behavioral aide will be paid the lower of the therapeutic behavioral aide's customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.

16.b All therapeutic behavioral aides, both government and nongovernment, are reimbursed pursuant to the same fee schedule. Therapeutic behavioral aides are paid a fixed amount per each 15 minute increments. The rate is published on the Agency's website at:
http://dhmh.maryland.gov/providerinfo

16.c The Agency reimburses schools for therapeutic behavioral aide services when required under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and when provided by a qualified therapeutic behavioral aide provider. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental therapeutic behavioral aides as described in 16b.

16.d Payment limitations:

- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
  - Completion of forms and reports;
  - Broken or missed appointments;
  - Professional services rendered by mail or telephone; and
  - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Maryland

EPSDT – Private Duty Nursing and Other Licensed Practitioners

17.a The Agency reimburses private duty nursing agencies for an initial assessment fee and supervisory visit. All other private duty nursing services are paid fixed amount per 15 minute intervals depending on whether the provider is serving one or more children. The rates are specified in the established and published fee schedule. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of private duty nursing, CAN/CMTs, and HHA/CMTs. The agency's fee schedule rate was set as of March 1, 2014 and is effective for services provided on or after that date. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. All rates are published at: http://dhmh.maryland.gov/providerinfo

17.b The Agency reimburses schools for private duty nursing services when required under an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and when provided by a qualified private duty nursing provider. The State will reimburse for this service at the same rate that it reimburses all other non-governmental private duty nursing providers in accordance with 17a and 17b.

17.c Payment limitations:

- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bills the Program or the recipient for:
  - Completion of forms and reports;
  - Broken or missed appointments;
  - Professional services rendered by mail or telephone; and
  - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

18. Licensed Mental Health Practitioners:

- **Certified Registered Nurse Practitioner with a specialty in Psychiatry**
- **Certified Advanced Practice Registered Nurse/Psychiatric Mental health**
- **Licensed clinical professional counselor and therapist**
- **Licensed Psychologist**
- **Licensed Clinical Social worker**

18a. The Agency reimburses a number of classes of private practitioners identified as "mental health professionals" differentially dependent on their licensure class. The classes eligible for reimbursement are licensed under State law and include nurse psychotherapists, licensed doctoral psychologists, licensed and certified social workers, licensed and certified professional counselors, and certified nurse practitioners. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan.

18b. Maryland bases the rates on market factors, primarily comparable rates from other insurers. For each class of mental health professional and for each CPT procedure code, rates paid by other insurers are reviewed. Since Maryland reimburses for a broader range of services than many insurers, some adjustments and interpolations are required. In order to establish rates for similar procedures are adjusted based upon time and intensity of effort required for the procedure in question. Whenever possible, rates are then benchmarked against Medicare rates for similar procedure codes. On average, State rates are below allowable Medicare rates. The rates were last set on 07/01/08 and can be found at: http://dhmh.maryland.gov/providerinfo

18c. The Agency reimburses schools for certain mental health services when required under an Individual Education Program (IEP) or Individual Family Service Plan (IFSP) and when provided by a licensed mental health provider. These services include: individual psychotherapy, family psychotherapy, group psychotherapy, and psychological testing. For all dates beginning January 1, 2010, the State will reimburse for this service at the same rate that it reimburses all other non-governmental metal health providers as described in 18b.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF MARYLAND

Specific Payment Procedures for Urgent Care Centers

A. Urgent care centers are reimbursed a $50 facility fee, which is determined by the Program. The rate is set as of January 1, 2014 and is effective for services provided on or after that date. The rate is the same for both governmental and private individual providers.

B. In addition to the facility fee, the Program shall reimburse for services rendered by the physician during the visit at the free-standing urgent care center when performed by a physician, or by other authorized personnel under that physician's supervision. The physician fee schedule and any annual/periodic adjustments to the fee schedule, are published on the DHMH website using the link provided: http://dhmh.maryland.gov/providerinfo

C. The provider may not bill the Program or the recipient for:

   1. Completion of forms or reports;
   2. Broken or missed appointments;
   3. Providing a copy or a recipient's medical record when requested by another licensed provider on behalf of the recipient.

D. The Program makes no direct payments to recipients.

E. The billing time limitations are set forth in the Preface to Attachment 4.19B.

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2a. OUTPATIENT HOSPITAL SERVICES

1) All hospitals located in Maryland which participate in the Program and are regulated by the All Payer Hospital Rate System, except those listed in 2 through 6 below, will charge-and payers will reimburse—according to rates approved by the HSCRC, pursuant to the HSCRC statue and regulation. Under this system, all regulated hospitals are required to submit to the HSCRC base year data using a uniform accounting and reporting system. The HSCRC established approved rates for units of service in the various revenue producing departments (rate centers). The rates include adjustments for such items as inflation, volume changes, pass-through costs, and uncompensated care. A description of the HSCRC's uncompensated care methodology is described in Attachment 4.19A Section 1. A. The HSCRC posts each hospital's rates by rate center on the HSCRC website:
http://www.hscrc.maryland.gov_Rates2.cfm

2) The Program will make no direct reimbursement to any Maryland State-operated chronic hospital, or psychiatric hospital.

3) An acute general or special hospital not located in Maryland or DC will be paid the host State Medicaid rate.

4) Beginning with fiscal year 2007, private freestanding pediatric rehabilitation hospitals in Maryland not approved for reimbursement according to the HSCRC rates, shall be reimbursed for outpatient expenditures using a prospective rate which is calculated based on the lower of cost from the Medicare 2552 Cost Report or up to 100% of outpatient charges. The percentage of charges reimbursed is adjusted annually by increasing the audited 2004 Medicare 2552 cost report trended forward times the Outpatient Prospective Payment System market basket update factor.

5) Psychiatric Hospitals Outpatient costs are reimbursed based on Medicare's retrospective cost reimbursement principles utilizing the Medicare cost report. The percentage of charges is calculated by taking outpatient charges divided by outpatient cost.
    a. Medicare standards for retrospective cost reimbursement described in 42 CFR Part 413 as filed in the Medicare 2552 cost report; or
    b. On the basis of charges if less than reasonable cost.
    In calculating retrospective cost reimbursement rates, the Program or its designee will deduct from the designated costs or group of costs those restricted contributions which are designated by the donor for paying certain provider operating costs, or groups of costs, or costs of specific groups of patients. When the cost, or group, or groups of costs, designated, cover services rendered to all patients, including MA recipients, operating costs applicable to all patients will be reduced by the amount of the restricted grants, gifts, or income from endowments thus resulting in a reduction of allowable costs.

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Disposable Medical Supplies and Durable Medical Equipment

Medical equipment services reimbursed above $1,000 and medical supply services reimbursed above $500 require prepayment authorization. A unit of service is an item and quantity as prescribed by the physician.

The Department does not pay for:

(1) Disposable medical supplies usually included with the office visit;
(2) Completion of forms and reports; and
(3) Fitting, dispensing, or follow-up care.

State-developed fee schedule rates are in effect as of July 1, 2012 and are the same for both governmental and private individual practitioners and are published on the DHMH website using the link provided:
https://dhmh.maryland.gov/communitysupport/Pages/Home.aspx

Oxygen and Related Respiratory Equipment

Payment for oxygen and respiratory equipment includes: equipment delivery, set up, training for use in the home, and data downloads. A unit of service is an item and quantity as prescribed by the physician.

Oxygen and related respiratory equipment services reimbursed above $1,000 and oxygen and respiratory supplies reimbursed above $500 require prepayment authorization.

The Department does not pay for:

(1) Completion of forms and reports; or
(2) Fitting, dispensing, or follow-up care.

State-developed fee schedule rates are in effect as of July 1, 2012 and are the same for both governmental and private individual practitioners and are published on the DHMH website using the link provided:
http://dhmh.maryland.gov/providerinfo

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Attachement 3.1A Item 12D: Eyeglasses

State-developed fee schedule rates are in effect as of July 1, 2011 and are the same for both governmental and private individual practitioners and are published on the DHMH website using the link provided, and selecting the most recent year's link:
http://dhmh.maryland.gov/providerinfo

The Department does not pay for:

(1) Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients 21 years old and older;
(2) Repairs, except when repairs to eyeglasses are more cost-effective than replacing with new eyeglasses; or
(3) Routine adjustments.

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3. Other Lab and x-ray Services: Laboratory Services

In accordance with CFR §440.30, laboratory services means a professional and technical laboratory service.

State-developed fee schedule rates are in effect as of July 1, 2012 and are the same for both governmental and private individual practitioners and are published on the DHMH website using the link provided:

http://dhmh.maryland.gov/providerinfo

The Department does not pay for:

(1) Services for which the medical laboratory provider cannot supply a properly completed order or standing order identifying the authorized ordering practitioner;
(2) Services not adequately documented in the recipient's medical records;
(3) Services denied by Medicare as not medically necessary;
(4) Clinical laboratory services, for which certification by CMS under CLIA is required, when these services are performed by laboratories that are not certified to perform those services;
(5) Procedures that are investigational or experimental in nature;
(6) Services included by the Program as part of the charge made by an inpatient facility, hospital outpatient department, freestanding clinic, or other Program-recognized entity;
(7) Medical laboratory services related to autopsies; or
(8) Medical laboratory services for which there was insufficient quantity of specimen, improper specimen handling, or other circumstances that would render the results unreliable.

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3. Other Lab and x-ray Services: Laboratory Services

In accordance with CFR §440.30, X-ray services means a professional and technical radiological service.

State-developed fee schedule rates are in effect as of July 1, 2012 and are the same for both governmental and private individual practitioners and are published on the DHMH website using the link provided:

http://dhmh.maryland.gov/providerinfo

The Department does not pay for:

(1) Services not medically necessary;
(2) Investigational and experimental drugs and procedures;
(3) Services denied by Medicare as not medically necessary; or
(4) Services which do not involve direct patient contact (face-to-face).

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Family Planning Clinics

State-developed fee schedule rates are the same for both governmental and private individual practitioners and are published on the DHMH website using the link provided:

http://dhmh.maryland.gov/providerinfo

Physicians are reimbursed based on the current fee schedule which is effective as of January 1, 2012. A unit of service is a visit or procedure as defined in the American Medical Association Current Procedural Terminology (AMA CPT). For dates of service between January 1, 2013 and December 30, 2014, provider rates for Evaluation and Management (E&M) procedure codes will be set at 100% of Medicare mean. In addition the State will pay the federally calculated VFC vaccine administration charge. The fee schedule is located by selecting the link for the Physicians Fee Schedule for the most recent year posted.

The Department does not pay for:

(1) Any services identified by the Department as not medically necessary or not covered;
(2) Investigational and experimental drugs and procedures;
(3) Visits solely for the purpose of one or more of the following;
    a. Prescription, drug or supply pick-up, or collection of laboratory specimens;
    b. Ascertaining the patient's weight; and
    c. Measurement of blood pressure;
(4) Injections and visits solely for the administration of injections;
(5) Immunizations required for travel outside of the Continental U.S.;
(6) Separate billing for services which are included as part of another service; or
(7) Separate reimbursement to a physician for services provided in a clinic in addition to the clinic reimbursement.

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Outpatient Mental Health Clinics

- The Mental Health Administration (MHA) reimburses Outpatient Mental Health Centers (OMHCs) for outpatient therapeutic treatment services on a per session basis. Sessions are delivered in units of time ranging from 20 minutes to 80 minutes. OMHCs may also be reimbursed for psychological testing and interpretation of test results. OMHC staff must include staff from two different licensed mental health professional classes, which include: psychiatrists, licensed doctoral psychologists, nurse psychotherapists, licensed and certified social workers, licensed and certified professional counselors, and certified nurse practitioners. Services and provider qualifications are limited to those outlined in Attachment 3.1A page 22 of the Maryland State Plan.

- Limitations:

    - All services must be preauthorized by the Mental Health Administration (MHA) or its designee;
    - MHA does not reimburse for outpatient mental health services provided to an individual when the individual is in a hospital, institution for mental disease (IMD), or residential treatment center;
    - MHA does not reimburse a psychologist for more than eight (8) hours of psychological testing per patient per year;
    - MHA does not reimburse services provided by a school health-related service provider that are not included on a child's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP);
    - MHA does not reimburse for services which do not involve direct, face-to-face, patient contact; and
    - MHA does not cover investigational and experimental drugs, procedures, or therapies.

- Both government and non-government practitioners are reimbursed pursuant to the same fee schedule. OMHCs are paid by CPT code or HCPCS codes which are based on Medicare reimbursement. The Agency's rates for OMHC providers are in effect as of July 1, 2016.

- State-developed fee schedule rates are the same for both governmental and private Outpatient Mental Health Clinics and are published: http://dhmh.maryland.gov/providerinfo

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Prosthetic Devices

A unit of service is an item and quantity as prescribed by the physician.

The Department does not pay for:

(1) Items which are investigational or experimental in nature; or
(2) Completion of forms and reports.

State-developed fee schedule rates are effective as of July 1, 2012 and are the same for both governmental and private practitioners and are published on the DHMH website using the link provided:

http://dhmh.maryland.gov/providerinfo

Reimbursement Methodology: Hospice Care

1. The Program will pay a hospice care provider at one of four rates for each day that a participant is under the provider's care. The daily payment rates for a provider for routine home care, continuous home care, general inpatient care, and inpatient respite care will be in accordance with the Medicaid payment rates and the Medicare Wage Index established by the Centers Medicare and Medicaid Services (CMS) of the U.S Department of Health and Human Services for hospice care under a Medical Assistance Program. The rates and wage index are effective for services provided on or after the CMS publication date. Except as otherwise noted in the plan, state developed fee schedules and rates are the same for both governmental and private providers. Rates and fees can be found by accessing: http://dhmh.maryland.gov/providerinfo

2. The four daily rates are prospective rates, and there will be no retroactive adjustment other than a limitation on payments for inpatient care.
    a. During the 12-month cap period beginning November 1 of each year and ending October 31 of the following year, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care the provider furnished to Medical Assistance hospice participants during the same period.

    b. If the aggregate number of inpatient care days exceeds the maximum allowable number, the limitation on reimbursement for inpatient care will be determined in accordance with the methodology established by CMS, and any excess reimbursement will be refunded to the Program by the provider.

    c. Any days of care furnished to participants diagnosed with Acquired Immune Deficiency Syndrome (AIDS) will be excluded in calculating the limitation on payment for inpatient care.

3. In addition to the daily rates for hospice care, the Program will make separate payment to the hospice care provider for physician services subject to the following requirements:

    a. The services must be direct patient care services furnished to a participant under the care of the provider;

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1915(b)(4) Waivers Maryland Community First Choice 4.19B
1915 – K Community First Choice State Plan Option Reimbursement

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers of services provided under the Community First Choice Option. The agency's fee schedule is effective for services provided on or after January 6, 2014. All rates are published at:
http://dhmh.maryland.gov/providerinfo

The following 1915(k) provider types are reimbursed in the manner described:

I. State Plan Services

A. Personal Assistance Services: Rates are established using several factors. Preexisting rates across programs, collective bargaining with the Union, and the State's budget are all considered. Payment is based upon the total yearly budget established for personal assistance services for each participant as outlined per attachment 3.1 - K, page 3. Participants choosing to self direct will be able to set their rate, for independent providers, within a prescribed range. Providers of this service use a call-in system to clock in and out. Billing occurs based on an electronic claim generated by the call-in system in 15 minute increments. All rates and rate ranges are defined in the above fee schedule.

B. Nurse Monitoring: The rate was developed based on preexisting rates across programs. The State also used rate comparisons of state salaries listed on the Department of Budget and Management website located at http://dbm.maryland.gov/Pages/home.aspx. As local health departments are sole providers of this service, in accordance with a 1915(b) waiver, one rate has been published for this service. Frequency for this service is established using criteria from the Maryland Nurse Practice Act. Billing occurs in 15 minute increments for this service.

C. Consumer Training: The rate was based on existing rates for the service. Billing occurs in 15 minute increments for the service provided to the participant.

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

Payment for Community Based Respite Care service as outlined per Attachment 3.1-i page 24-25 and is reimbursed at an hourly unit of service. Community Based Respite Care providers are defined per Attachment 3.1-i page 25-26.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhmh.maryland.gov/providerinfo . State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

OUT OF HOME RESPITE CARE

Out of Home respite services are provided on an overnight basis for a minimum of 12 hours, and are reimbursed using a flat per diem rate. The service has a maximum of 24 units per year, subject to medical necessity criteria override. The service may not be billed on the same day as community-based 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.

Payment for Out Of Home Respite Care service as outlined per Attachment 3.1-i page 24-25 and is reimbursed at a hourly unit of service. Out Of Home Respite Care providers are defined per Attachment 3.1-i page 25-26.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhmh.maryland.gov/providerinfo. State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

For Individuals with Chronic Mental Illness, the following services:

☐ HCBS Day Treatment or Other Partial Hospitalization Services

☑ HCBS Psychosocial Rehabilitation

Intensive In-Home Services (IIHS) - EBP

Personnel	Annual Amount or Rate	% FTE	Salary Cost	Fringe Benefits (25%)	Salary + Fringe Cost
Therapist	$ 50,000	1	$ 50,000	$ 12,500	$ 62,500.00
Supervisor/Clinical Lead	$ 75,000	0.20	$ 15,000	$ 3,750	$ 18,750.00
Clinical Director	$ 100,000	0.09	$ 9,000	$ 2,250	$ 11,250.00
Quality Assurance/Management Info. Systems Director	$ 90,000	0.09	$ 8,100	$ 2,025	$ 10,125.00
Admin. 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

a. are derived from rigorous, scientifically controlled research; and
b. can be applied in community settings with a defined clinical population;
2. has a consistent training and service delivery model;
3. utilizes a treatment manual; and
4. has demonstrated evidence that successful program implementation results in improved, measureable 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.

Payment for Intensive In-Home service as outlined per Attachment 3.1-i page 15-16 and is reimbursed a weekly unit of service. Intensive In-Home providers are defined per Attachment 3.1-i page 16-19.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhmh.maryland.gov/providerinfo. State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

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

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.

Payment for Intensive In-Home service as outlined per Attachment 3.1-i page 15-16 and is reimbursed a weekly unit of service. Intensive In-Home providers are defined per Attachment 3.1-i page 16-19.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhmh.maryland.gov/providerinfo. State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

MOBILE CRISIS RESPONSE SERVICES

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.

Payment for Mobile Crisis Response service as outlined per Attachment 3.1-i page 19 and is reimbursed per fifteen minute unit of service. Mobile Crisis Response providers are defined per Attachment 3.1-i page 21-22.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhmh.maryland.gov/providerinfo. State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

EXPRESSIVE AND 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	75-90 minutes	$31.41
Expressive Therapies--Group, non LMHP	45-60 minutes	$27.20
Expressive Therapies--Group, non LMHP	75-90 minutes	$35.36

LMHP=Licensed Mental Health Practitioner

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.

Payment for Expressive and Experiential Behavioral service as outlined per Attachment 3.1-i page 29-30 and is reimbursed either a 45-50 unit of service or a 75-80 unit of service. Expressive and Experiential Behavioral providers are defined per Attachment 3.1-i page 27-29.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at http://dhmh.maryland.gov/providerinfo. State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

FAMILY 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

Billable Time		
Family Support Partner	2080	Total work hours per year (8 hour day * 260 days)
Family Support Partner Supervisor		
Administrative Assistant	160	Vacation, sick & holiday leave: 20 days@8 hours per day
Billing Support Specialist	128	Training: 16 days @8hours per day

		provided on or after that date. All rates are published on the agency's website at http://dhmh.maryland.gov/providerinfo. State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)	
	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. Reimbursement for purchases under the Goods and Services benefit will require prior approval and be reviewed on a per request basis. Prior to reimbursement, it must be demonstrated that the purchaser received multiple quotes and paid a price that a prudent buyer would have paid. Claims under this benefit will be capped at $2,000 per year per beneficiary. The state must adhere to CMS record keeping requirements (42 CFR §431.107) and providers must keep records of documented medical necessity for CGS 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;	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Maryland

Community Personal Assistance Services 4.19B
State Plan Option Reimbursement

1) Effective October 1, 2015, payments for community personal assistance services as defined per Attachment 3.1A page 31B shall be reimbursed in 15-minute units. Both government and non-government providers of community personal assistance services are reimbursed pursuant to the same fee schedule. The fee schedule is effective for services provided on or after October 1, 2015 and are published on the Department's website at: http://dhmh.maryland.gov/providerinfo.

2) Payment limitations:
   - The provider may not bill the Department or the recipient for:
     - Missed or broken appointments; and
     - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.