DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

April 25, 2025

Ryan Moran, Deputy Secretary and State Medicaid Director
Maryland Department of Health
201 W Preston Street, Room 525
Baltimore, MD 21201

RE: MD-25-0002, Intensive Behavioral Health Services for children, Youth, and Families §1915(i) home and community-based services (HCBS) state plan amendment (SPA)

Dear Director Moran:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(i) state plan home and community-based services (HCBS) benefit, transmittal number MD-25-0002. The effective date for this amendment is April 1, 2025. With this amendment, the state is updating the timeframe during which a face-to-face psychosocial assessment must be completed or updated to within 60 days of submission of the application to the Administrative Services Organization; expanding participant eligibility to include a score of 2 for both the Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ECSII); expanding participant eligibility so participants who receive a score of 5 or higher on the CASII do not have to meet additional needs-based criteria; updating the frequency for Plan of Care (POC) reviews and Child and Family Team meetings from every 30 days to every 60 days; removing the separate reimbursement for telephonic peer support services and clarifying that Family Peer Support Services can be provided in-person and via audio-visual and audio-only telehealth, and consolidating the maximum units of service to 27 hours per month; and adding coverage of Youth Peer Support Services.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-I pg. 1-52 (24-0008)
- Attachment 3.1-I pg. 53-54 (NEW)
- Attachment 4.19-B pg. 54-59 (24-0008)

It is important to note that CMS' approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Alice Robinson Ross at Alice.RobinsonRoss@cms.hhs.gov or (215) 861-4261

Sincerely,

[redacted]

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Katherine Berland, CMS DMEP
Ysabel Gavino, CMS FMG
Daphne Hicks, CMS DLTSS
Talbatha Myatt, CMS DPO
Dominique Mathurine, CMS DHCBSO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0002

2. STATE: MD

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.201

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 5,747,337
b. FFY 2026 $ 5,747,337

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-I pg. 1-54 ~~(24-0008)~~ (25-0002)
Attachment 4.19-B Pg. 54-59 ~~(24-0008)~~ (25-0002)
~~Attachment 2.2-A pg. 27-28 (24-0008)~~

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-I pg. 1-52 (24-0008)
Attachment 4.19-B Pg. 54-59 (24-0008)
~~Attachment 2.2-A pg. 27-28 (24-0008)~~
Attachment 3.1-I pg. 53-54 (NEW)

9. SUBJECT OF AMENDMENT
The State is proposing the following changes to the 1915(i) program - Increase the timeframe that a face-to-face psychosocial assessment must be completed or updated, expand participant eligibility, update the frequency for POC reviews and Child and Family Team meetings, remove the separate reimbursement for telephonic peer support services and clarify that Family Peer Support Services can be provided in person and via AV and audio-only telehealth, and add coverage of Youth Peer-Support Services.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Tricia Roddy

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED
February 18, 2025

15. RETURN TO
Ryan Moran
Medicaid Director
Maryland Department of Health
201 W. Preston St., 5th Floor
Baltimore, MD 21201

FOR CMS USE ONLY

16. DATE RECEIVED
February 18, 2025

17. DATE APPROVED
April 25, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations and Oversight

22. REMARKS
April 10, 2025: state authorize P&I to box 7 & 8

Instructions on Back

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):*

- Intensive In-Home Services
- Community-Based Respite Care
- Out-of-Home Respite Care
- Family Peer Support
- Expressive and Experiential Behavioral Services
- Youth Peer Support

2. **Concurrent Operation with Other Programs.** *(Indicate whether this benefit will operate concurrently with another Medicaid authority):*

Select one:

◉	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*
(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);
(b) the geographic areas served by these plans;
(c) the specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1115 of the Act.** *Specify the program:*

3. 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 *Maryland Department of Health-Behavioral Health Administration*	
	This HCBS benefit is operated by the Behavioral Health 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 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.	

4. 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 Eligibility evaluation	✔	✔	✔	
3 Review of participant service plans	✔		✔	✔
4 Prior authorization of State plan HCBS	✔		✔	
5 Utilization management	✔	✔	✔	
6 Qualified provider enrollment	✔	✔	✔	
7 Execution of Medicaid provider agreement	✔	✔		
8 Establishment of a consistent rate methodology for each State plan HCBS	✔	✔		
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	✔	✔		
10 Quality assurance and quality improvement activities	✔	✔		

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

1. The State Medicaid Agency performs individual state HCBS enrollment.
2. The State Medicaid Agency performs eligibility evaluation in partnership with the contracted Administrative Services Organization (ASO) and the Behavioral Health Administration (BHA).
3. The BHA, ASO, and the local Core Service Agency (CSA)/Local Behavioral Health Authority (LBHA) perform reviews of participant services plans.
4. The ASO is responsible for prior authorization of State Plan HCBS
5. The State Medicaid Agency is responsible for utilization management in partnership with the ASO and the BHA.
6. The State Medicaid Agency works in partnership with the ASO and the BHA to perform qualified provider enrollment.
7. The State Medicaid Agency works in partnership with the BHA to execute the Medicaid provider agreement.
8. The State Medicaid Agency and the BHA work in partnership to establish a consistent rate methodology for each State plan HCBS.
9. Rules, policies, procedures, and information development governing the State plan HCBS benefit are developed by the State Medicaid Agency in partnership with the BHA.
10. Quality assurance and quality improvement activities are performed by the State Medicaid Agency, the BHA, and the ASO.

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

5. ☒ **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):*

6. ☒ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. ☒ **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.
8. ☒ **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 Education 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	10/1/24	9/30/25	200
Year2	10/1/25	9/30/26	600
Year3	10/1/26	9/30/27	1,000
Year4	10/1/27	9/30/28	1,400
Year 5	10/1/28	9/30/29	1,800

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. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.

☒ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☒ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

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 Behavioral Health Administrative Services Organization (ASO) is the entity contracted by the State Medicaid Agency that is responsible for the independent evaluation and reevaluations.

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 independent evaluation and reevaluation will be completed by the Administrative Services Organization (ASO) on behalf of the Department. Maryland-licensed mental health professionals trained in the use of the applicable standardized tools will perform the evaluations. This may include Psychiatrists, Nurse Psychotherapists (ARNP-PMH), Psychiatric Nurse Practitioners (CRNP-PMH), Licensed Clinical Social Workers, Licensed Clinical Professional Counselors, or a Psychologist.

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 Department will verify eligibility, perform the independent evaluation of needs-based criteria, and pre-authorize all of the medically appropriate mental health services. Final eligibility determination rests with the SMA and the ASO will present its 1915(i) eligibility determination to the Department for final approval and enrollment.

The evaluator will utilize a psychosocial assessment to generate a score on the ECSII or CASII for the youth.

Specific 1915(i) eligibility criteria, including re-evaluation criteria, are outlined in #5 below.

Re-Evaluation;
The ASO will review the most recent POC along with other documentation including financial eligibility at least annually as part of the review for continued eligibility for 1915(i) services. The medical re- evaluation, including a CASII or ECSII, 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 2 to 6 or ECSII score of 2 to 5) as outlined in Section 1a of the response below to Question 5 "Needs-based HCBS Eligibility Criteria";
3. A review of HCBS benefits service utilization over the past 6 months.

The ASO will make the final re-evaluation determination and inform the SMA of its decision.

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):*

A child or youth must demonstrate the following minimum requirements to be considered for or to remain in 1915(i) services:

1. Impaired Functioning & Service Intensity: A licensed mental health professional (including Psychiatrists, Nurse Psychotherapists (ARNP-PMH), Psychiatric Nurse Practitioners (CRNP- PMH), Licensed Clinical Social Workers, Licensed Clinical Professional Counselors, or Psychologists) must complete or update a comprehensive psychosocial assessment within 60 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 an impairment in functioning, representing potential harm to self or others, across settings, including the home, school, and/or community. The potential harm does not necessarily have to be of an imminent nature. The score 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 must be supported by the findings of the psychosocial assessment.
    a. Youth must receive:
        i. A minimum score of 2 (low service intensity for an acute or ongoing concern) on the ECSII; or
        ii. A minimum score of 2 (outpatient services) on the CASII.
    b. For initial evaluation, youth must be 6 to under 18 years old. If they receive a score of 2-4 on the CASII, they must also meet one of the following criteria to be eligible:

i. Have a combination of 2 or more inpatient psychiatric hospitalizations, ER visits, crisis stabilization center visits, or mobile crisis team responses in the past 12 months; or

ii. Been in an RTC within the past 90 days.

c. For initial evaluation, if youth who are younger than 6 years old score a 2-4 on the ECSII, they must also meet one of the following criteria to be eligible:

i. Be at an increased risk of long-term behavioral health challenges impacting emotional regulation, peer relationships, and the ability to engage in age-appropriate learning and social development as evidenced by areferral directly from an inpatient or day hospital unit, PCP, outpatient psychiatric facility, ECMH Consultation Program in daycare, Head Start, Early Head Start, Judy Hoyer Centers, or home visiting programs; or

ii. Have one or more psychiatric inpatient or day hospitalization, ER visit, crisis stabilization center visit, mobile crisis team response, exhibit severe aggression (i.e., hurting or threatening actions or words directed at infants, young siblings, killing a family pet, etc.), display dangerous behavior (i.e., impulsivity related to suicidal behavior), been suspended or expelled or at risk of expulsion from school or child care setting, display emotional and/or behavioral disturbance prohibiting their care by anyone other than their primary caregiver, at risk of out-of-home placement or placement disruption, have severe temper tantrums that place the child or family members at risk of harm, have trauma exposures and other adverse life events, or at risk of family related risk factors including safety, parent-child relational conflict, and poor health and developmental outcomes in the past 12 months.

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/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
A child or youth must demonstrate the following minimum requirements to be considered for 1915(i) services: 1) Impaired Functioning & Service Intensity: A recent psychosocial assessment must outline how, due to the behavioral health disorder(s), the child or adolescent exhibits an impairment in functioning, representing potential harm to self or others, across settings, including the home, school, and/or community. The potential harm does not necessarily have to be of an imminent nature. The score of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0- 5 or	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.	The medical necessity criteria for developmental disability as set forth in Md. Code Reg. 10.22.01.01: (16) "Developmental disability" as a chronic disability of an individual that: (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; Is likely to continue indefinitely; (c) Is manifested in an individual younger than 22 years old; (d) Results in an inability to live independently without external support or continuing and regular assistance; and (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.	For inpatient hospital psychiatric emergency detention or involuntary admission, Md. Health Gen. §§ 10-613 through 619 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. 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

the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6- 21 must be supported by the findings of the psychosocial assessment. a. Youth must receive a minimum score of 2 on the ECSII, or a minimum score of 2 on the CASII. b. For initial evaluation, youth must be 6 to under 18 years old. If they receive a score of 2-4 on the CASII, they must also meet one of the following criteria to be eligible: i. Have combination of 2 or more inpatient psychiatric hospitalizations, emergency room visits, crisis stabilization center visits, or mobile crisis team responses in the past 12 months; or ii. Been in an RTC within the past 90 days.			(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

c. For initial evaluation, if youth who are younger than 6 years old score a 2,-4 on the ECSII, they must also meet one of the following criteria to be eligible: i. Be at risk of long-term behavioral health challenges impacting emotional regulation, peer relationships, and the ability to engage in age-appropriate learning and development as evidenced by a referral directly from an inpatient hospital or day hospital, PCP, outpatient psychiatric facility, ECMH Consultation Program in daycare, Head Start, Early Head Start, Judy Hoyer Centers, or home visiting programs unit; or ii. Have one or more psychiatric inpatient hospitalization, ER visit, crisis stabilization center visit, or mobile			

crisis team response in the past 12 months.			

*Long Tenn 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) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

This HCBS benefit is targeted to youth and young adults with serious emotional disturbances (SED) or co-occurring mental health and substance use disorders and their families.

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. Behavioral Health Disorder:
   Youth must have a behavioral health disorder amenable to active clinical treatment.

There must be clinical evidence the child or adolescent has a serious emotional disturbance (SED) or co-occurring diagnosis and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. *(Specify the phase-in plan):*

(By checking the following box 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. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: A participant requires at least one 1915(i) State Plan service to be determined to need the 1915(i) State Plan HCBS benefit.
ii.	**Frequency of services.** The state requires (select one):
◉	**The provision of 1915(i) services at least monthly**
○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. This may include residence in:

1) a home or apartment with parents, family, or legal guardian or living independently, that is not owned, leased or controlled by a provider of any health-related treatment or support services; or

2) a home or apartment that is a licensed family foster care home or a licensed treatment foster care home. These are not group homes with staff providing services. These settings are the private homes of foster parents who must meet a number of standard environmental and physical space dimensions of the home which are geared toward the individual needs of the children who live there. Foster home licensing also requires ongoing training for the foster parents, with more rigorous training, support, and consultation for treatment foster parents.

The ASO confirms the individual resides in a home and community-based setting during the evaluation of eligibility. Ongoing, settings are reviewed by Care Coordination Organizations (CCOs).

The State monitors compliance of the home and community-based settings requirement annually as part of the Quality Improvement Strategy (QIS).

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 meets federal requirements at 42 CFR §441.720.

2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **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 and family'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. Qualifications for Care Coordination Organizations (CCOs) are described in COMAR 10.09.90, and all 1915(i) participants are required to receive care coordination services under the same regulations. The State Plan Amendment pages for Care Coordination for Children and Youth include detailed requirements for CCOs. Care Coordinators employed by the CCO must demonstrate the following:

i. Bachelor's degree and has met the Department's training requirements for care coordinators; or
ii. A high school diploma or equivalency and
   a. Is 21 years or older; and
   b. Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who received services from the public and child- and family-serving system; and
   c. Meets the training and certification requirements for care coordinators as set forth by the Department.
   d. Is employed by the CCO to provide care coordination services to participants; and
   e. Provides management of the POC and facilitation of the team meetings.

5. **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 Care Coordination model, facilitated by the CCO. Qualifications for Care Coordination Organizations (CCOs) are described in COMAR 10.09.90, and all 1915(i) participants are required to receive care coordination services under the same regulations. The State Plan Amendment pages for Care Coordination for Children and Youth include detailed requirements for CCOs. Care Coordinators employed by the CCO must demonstrate the following:

i. Bachelor's degree and has met the Department's training requirements for care coordinators; or
ii. A high school diploma or equivalency and

a. Is 21 years or older; and
b. Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who received services from the public and child- and family-serving system; and
c. Meets the training and certification requirements for care coordinators as set forth by the Department.
d. Is employed by the CCO to provide care coordination services to participants; and
e. Provides management of the POC and facilitation of the team meetings.

iii. Care Coordinators may not be related by blood or marriage to the individual, or any paid caregiver of the individual, to whom they deliver care coordination services.

The Clinical Director, a licensed mental health professional, will supervise the development and ongoing implementation of the POC and review and approve the POC.

A core element of the Care Coordination model is the team approach. This team includes 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 as available. The team should meet regularly and revisit the POC during meetings.

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 at a minimum every 6 months by the Care Coordinator to support identification of strengths and needs for care planning. Information from the family and their identified supports is incorporated as a part of the process.

6. **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. One of the key philosophies in the Care Coordination 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. The CCO is responsible for working with the participant, family, and team to develop the Plan of Care through the process outlined below.

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, participant, and family after enrollment, the CCO will:

(a) Administer the appropriate assessments, as designated by the Behavioral Health Administration (BHA);
(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 Care Coordination process; and
(d) Facilitate the family sharing their story.

The CCO will, with the participant and family: conduct a strengths-based initial assessment of the participant, their family members, and potential team members to identify needs in the planning process; determine team meeting attendees; contact potential team members, provide them with an overview of the Care Coordination process, and discuss expectations for the first team meeting. Within 30 days of notification of enrollment, the CCO will offer the participant and family the opportunity to determine whether and how to use peer support in the development and implementation of the POC.

The team, 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 60 days to coordinate the implementation of the POC and update the POC as necessary.

Before the provision of services in the POC, BHA or its designee shall review and authorize the services designated in the POC. The CCO in collaboration with the team shall reevaluate the POC at least every 60 days with re-administration of BHA-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 care coordination services. The participant/family will sign and date 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 Care Coordination process of building my family's Plan of Care."

7. **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):*

BHA or its designee will have and maintain a database and/or directory available to the CCO and the family from which to choose providers to implement the plan of care. Providers are selected by team with the support of the CCO. Participants are active members 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.

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

Care Coordination is a team-level decision making process with each party accountable for ensuring high quality services for the individual and family. The team determines the supports and services that need to be in place for the family, with the family and youth driving the process. The Care Coordination Organization (CCO) will manage the Plan of Care (POC). The Clinical Director, a licensed mental health professional employed by the CCO, will supervise the development and ongoing implementation of the POC and review and approve the POC. Prior to the provision of services in the POC, BHA or its designee will review and authorize the services designated in the POC based on medical necessity criteria for all Medicaid services. The POC will be provided to BHA or its designee to ensure that authorized services are consistent with the POC.

All services made available in the 1915(i) and Public Behavioral Health System will address individualized needs and are assessed for meeting medical necessity criteria. Choice of providers is a primary responsibility for families. If a family is dissatisfied with a provider, the CCO will handle the situation using an internal process to address the family's needs, mediate as applicable, or support a transition to another provider. This includes dissatisfaction with CCOs and any other providers. Each CCO has its own internal grievance process as part of their policies and procedures. Any unresolved grievances against the CCOs are resolved at the CSA/LBHA level.

The POC process is designed to identify and address the individualized needs of each family. If a plan is not working for the family, the plan is revisited and redesigned to better meet their needs. The team shares the philosophy that "the family doesn't fail, the plan fails" and in turn needs to be re- developed. Families' needs and strengths will be identified in part through the CANS.

The CCO is responsible for monitoring service providers' implementation of plans of care. BHA or its designee will review a sample of plans of care, review participant records, and track and trend the results as part of quality management activities in line with the quality assurance plan outlined below. Results of ongoing monitoring activities for reportable events reports, and annual reports, according to the quality improvement strategies, will be provided to the Medicaid Agency. The Medicaid Agency will review the quarterly and annual reports that are prepared by the ASO. To address any service deficiencies, the Medicaid Agency will work in collaboration with BHA 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

9. 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

1. 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: **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 twice each week, including at least one in-person contact. IIHS includes a series of components, including functional assessments and treatment planning, individualized interventions, transition support, and in some cases, crisis response and intervention.

IIHS may be provided to the child alone, to other family members, and to the child and family members together. The services provided to other family members are essential to the positive course of treatment of the youth enrolled in the program. Examples of this include strengthening a caregiver's ability to manage challenging child behaviors, developing skills in setting appropriate boundaries with the child, and developing de-escalation skills that are necessary to stabilize the young person and the home setting. The IIHS treatment plan must be integrated with the overall POC, and the IIHS providers must work with the team 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 or stabilize after a crisis situation.

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. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose 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 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 Behavioral Health System or HCBS benefit services.
	Medically needy *(specify limits)*:

✔ Service limits are the same as those for the categorically needy.

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 10.63.03	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 MDH 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. MDH will maintain a publicly available list of practices that meet the criteria for intensive in-home services, including but not limited to Family Centered Therapy (FCT) and In-Home Intervention Program For Children (IHIP-C). Providers of Intensive In-Home Services must ensure that 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 2) For IIHS models including an on-call and crisis intervention element, these services, are: i) Provided by a licensed mental health professional (psychiatrist, psychologist, nurse psychotherapist (APRN-PMH), psychiatric nurse practitioner (CRNP- PMH) LCSW-C, LCSW, or LCPC) trained in the intervention; and, 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, iii) The program complies with staffing, supervision, training, data collection and fidelity monitoring requirements set forth by the purveyor, developer, or MDH and approved by the Department. 3) Clinical Leads and Supervisors must: a) Have a current license as either 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, b) Have at least three years of experience in providing mental health treatment to children and families. 4) Therapists must: a) Have either 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; and b) Be supervised by a Clinical Lead or Supervisor; and c) See the child in-person at least once in a seven (7) day period 5) In-home stabilizers a) Support the implementation of the treatment plan b) Must be at least 21 years old; c) Must have at least a high

			school diploma or equivalency; and d) Must have completed relevant, comprehensive, appropriate training prior to providing services, as outlined by the purveyor, developer, or MDH and approved by MDH. 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	BHA verifies provider approvals such as PRP, OMHC if applicable. BHA certifies programs not approved by BHA 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: **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 10.63.03.15).

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. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose 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 Behavioral 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 Behavioral Health System respite services.

The limit may be exceeded only by determination of need in accordance with the person-centered service plan and the participant directed budget. Individuals who may require services beyond the stated limit may work with their care coordinator and service provider to request additional service authorization by the ASO. The ASO will review the request for medical necessity and demonstrated need to extend the service beyond the limit, based on criteria developed by the Department.

The limit on community-based respite is six hourly units allowed in a given day. Thus service provision that might exceed this daily limit may be a situation better suited to use of the out-of-home respite service which can cover up to a 24 hour period. The two respite care services are treated as a continuum of options for providing caregivers with a break

✔ Medically needy *(specify limits)*:

Service limits are the same as those for the categorically needy.

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	Health Occupations Article, Annotated Code of Maryland and COMAR 10.63.03.15		Community Based Respite Care Providers Must: A. Meet the in-home respite care requirements of COMAR 10.63.03.15, as determined by the Maryland Department of Health; B. Ensure that respite care staff are: a. 21 years old or older and have a high school diploma or other high school equivalency; or b. When providing services to participants under age 13, at least 18 years old and enrolled in or in possession of at least an associate or bachelor's degree from

			an accredited school in a human service field. C. Ensure that community-based respite services are provided in the participant's home or other community-based setting; and, D. Follow the program model requirements outlined in COMAR 10.63.03.15 for screening, assessment, staff training and expertise, provision of care, and conclusion of respite episode. Providers are approved by the Maryland Department of Health

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	Administrative Service Organization on behalf of the Department	BHA: At the time of enrollment and at least every three years 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 Behavioral 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. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(*Choose 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 ongoing day care or before or after school programs.

The service is automatically authorized for a 60 day period after enrollment for any individual meeting the eligibility criteria of this 1915(i) State Plan Amendment. This is not to say that the Out-of-home respite episode would be 60 days in duration, as it is generally offered as a single overnight or in some cases, as a weekend of respite care for a family. After this initial 60-day period, 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. This limit is based on the framework of up to one weekend of respite care in a given month, or similar reasonable configuration.

The limit may be exceeded only by determination of need in accordance with the person-centered service plan and the participant directed budget. Individuals who may require services beyond the stated limit may work with their care coordinator and service provider to request additional service authorization by the ASO. The ASO will review the request for medical necessity and demonstrated need to extend the service beyond the limit, based on criteria developed by the Department.

✔ Medically needy *(specify limits)*:

Service limits are the same as those for the categorically needy.

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	Health Occupations Article, Annotated Code of Maryland and COMAR 10.63.03.15		Out-of-Home Respite Care Providers must: A. Meet the out-of-home respite care requirements of COMAR 10.63.03.15, as determined by the Maryland Department of Health. B. Ensure that respite care staff are: a. 21 years old or older and have a high school diploma or other high school equivalency; or b. When providing services to participants under age 13, at least 18 years old and enrolled in an accredited post-secondary educational institution or in possession of at least an associate or bachelor's degree from an accredited school in a human services field. C. Ensure that out-of-home respite services are provided in a community-based alternative living arrangement outside the participant's home, in accordance with COMAR 14.31.05-.07, where applicable D. Follow the program model requirements outlined in COMAR 10.63.03.15 for screening, assessment, staff training and expertise, provision of care, and

			conclusion of respite episode. Providers are approved by the Maryland Department of Health.

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	BHA initial verification of license or approval Administrative Service Organization on behalf of the Department	BHA: At the time of enrollment and at least every three years 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 with lived experience who will do some or all of the following, depending on the Plan of Care developed by the CCO, Care Coordinator, and family. These services are specifically supportive of parents and caregivers rather than the child in need and contribute to the overall POC implementation. These services designed to assist families who would otherwise have difficulty engaging the care coordination/treatment process due to a history of accumulated negative experiences with the system which act as a barrier to engagement. The family peer support specialist employed by the Family Support Organization (FSO):

- Participate as a member of the Child/Youth Family Team meetings
- Explain role and function of the FSO to newly enrolled families and at the direction of the CCO 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; and 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 care coordination 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 team 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. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose 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 Behavioral Health System or HCBS benefit services. Family peer support may be provided, and billed, for meeting with the family in-person and via audio-visual and audio-only telehealth. Family peer support may not be billed for telephonic communications with other providers or resources. Service limits for family peer support is limited to 27 hours per month, unless specially approved by BHA 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	The National Certification for Family Peer Specialists (CFPS) or another BHA approved entity. The provider may have the certificate, be in the process of obtaining it or under the supervision of an individual who has the	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 Revenue Service Code, and submit copies of the certificate of incorporation and Internal Revenue Service designation; (2) Establish hiring practices that give preference to current or previous caregivers of youth with behavioral health challenges

		certification.	

			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; 3) Employ a staff that is comprised of at least 50% 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 4) Maintain general liability insurance to provide family peer support. The peer support provider shall: (1) Be employed by a Family Support Organization; (2) Be at least 18 years old; (3) Receive supervision from an 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; and (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.

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 Department	BHA: At the time of enrollment and at least every five years ASO

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 MDH'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. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose 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. Participants may receive a maximum of two different expressive and experiential behavioral services on the same day.

✔ Medically needy *(specify limits)*:

Service limits are the same as those for the categorically needy.

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 Maryland Department of Health. 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. To provide a particular expressive and experiential behavioral service, an individual shall have: (a) A bachelor's or master's degree

			from an accredited college or university; and (b) Current registration in the applicable certification body: • Art Therapist certified by the Art Therapy Credentials Board in the American Art Therapy Association or licensed as a Licensed Clinical Professional Art Therapist (LCPAT) • Registered Dance Therapist or Dance Therapists Registered by the American Dance Therapy Association • Equine Therapist certified by the Equine Assisted Growth and Learning Association (EAGALA) or the Professional Association of Therapeutic Horsemanship International (PATH Int.) (formally the North American Riding for the Handicapped Association (MARHA)) • Horticultural Therapist registered by the American Horticultural Therapy Association • Music Therapist 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 • A comparable association with equivalent requirements The Maryland Department of Health will maintain a publicly available list of Certification Bodies. 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 Department	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: **Youth Peer Support**

Service Definition (Scope):

Youth Peer Support services promote recovery and wellness through structured one-to-one strength-based support services between a peer and a youth for the purpose of addressing daily living, social, and communication needs. Youth peer support staff are individuals with lived experience. Services are individualized and may include the following, depending on the Plan of Care developed by the CCO, Care Coordinator, and family:

- Promoting wellness through modeling
- Assisting the youth with understanding the person-centered planning process
- Coaching, supporting, and training in order to ensure the youth's success in navigating various social contexts, learning new skills, and making functional progress
- Coaching the youth to understand the care planning process and articulate goals during the person-centered planning process
- Providing mutual support, hope, reassurance, and advocacy that include sharing one's own personal story
- Serving as an advocate, mentor, or facilitator for resolution of issues
- Helping the youth develop self-advocacy skills and gain the ability to play a proactive role in their own treatment
- Skills development for coping with and managing behavioral health symptoms and trauma, wellness, resiliency, and recovery support

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. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose 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 Youth Peer Support may not be duplicative of other Public Behavioral Health System or HCBS benefit services. Youth peer support may be provided, and billed for meeting with the youth in-person and via audio-visual and audio-only telehealth. Youth peer support may not be billed for telephonic communications with other providers or resources. Service limits for youth peer support is limited to 27 hours per month, unless specially approved by BHA for higher levels.
✔	Medically needy *(specify limits):*
	Service limits are the same as those for the categorically needy.

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

Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

	Certified peer recovery specialist	N/A	Maryland certification for Peer Recovery Specialist (CPRS) or another BHA approved entity. The provider may have the certificate, be in the process of obtaining it or under the supervision of an individual who has the certification.	Youth peer supports must be provided by a certified peer recovery specialist employed by a Family Support Organization (FSO) as defined per Attachment 3.1-i pages 30-31. Youth peer recovery specialists must: (1) Be at least 18 years of age but may not provide youth peer supports to 1915(i) enrollees older than them. (2) Self-identify as a person in long-term recovery from the effects of a behavioral health disorder for a period of two years or more. (3) Be supervised by an individual who is at least 21 years old and has at least three years of experience providing family or youth peer support or working with children with serious behavioral health challenges and their families; and (4) Be an individual with experience with State or local services and systems as a consumer who has or had behavioral health challenges.

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)*:
Certified peer recovery specialist	Administrative Service Organization on behalf of the Department	BHA: At the time of enrollment and at least every five years ASO

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

	Participant-directed	✔	Provider managed

2. ☐ **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; (e) 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)*:

Participant-Direction of Services

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

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):*

a. 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):*

b. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness 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):*

c. 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
	☐	☐
	☐	☐

d. 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 administration of the Medicaid State plan.

e. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

7. 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):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority *(individual can select, manage, and dismiss State plan HCBS providers). (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 that does not result in payment for medical assistance to the individual). (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 the method for calculating the dollar values in the budget based on reliable costs and service utilization, 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.):*
	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.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

3. Providers meet required qualifications.

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

5. The SMA retains authority and responsibility for program operations and oversight.

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	1a) Service plans address the assessed needs of 1915(i) participants
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of service plans that adequately address the assessed needs of 1915(i) participants
Discovery Activity *(Source of Data & sample size)*	Defensible sample of case files (electronic or paper) of participants who were enrolled during the time period under review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA with CSAs/ LBHAs

Requirement	1a) Service plans address the assessed needs of 1915(i) participants
Frequency	Every 12 months
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with CSAs/ LBHAs
Frequency *(of Analysis and Aggregation)*	If a performance improvement plan is needed, a CCO program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to BHA, ASO, and CSA/LBHA, as applicable, within 30 working days of notice of program deficiencies. The CSA/LBHA will follow up with the program 3 months after the final implementation of the performance improvement plan.

Requirement	1b) Service plans are updated annually
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans that are updated at least once in the last 12 months
Discovery Activity *(Source of Data & sample size)*	Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA with CSAs/ LBHAs

Requirement	1b) Service plans are updated annually
Frequency	Every 12 months
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with CSAs/ LBHAs
Frequency *(of Analysis and Aggregation)*	If a performance improvement plan is needed, a CCO program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to BHA, ASO, and CSA/LBHA, as applicable, within 30 working days of notice of program deficiencies. The CSA/LBHA will follow up with the program 3 months after the final implementation of the performance improvement plan.

Requirement	1c) Service plans document choice of services and providers
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of participants whose POC indicates they were afforded choice in the selection of services and providers
Discovery Activity *(Source of Data & sample size)*	Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA with CSAs/LBHAs

Requirement	1c) Service plans document choice of services and providers
Frequency	Every 12 months
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with CSAs/ LBHAs
Frequency *(of Analysis and Aggregation)*	If a performance improvement plan is needed, a CCO program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to BHA, ASO, and CSA/LBHA, as applicable, within 30 working days of notice of program deficiencies. The CSA/LBHA will follow up with the program 3 months after the final implementation of the performance improvement plan.

Requirement	2a) Eligibility Requirements: an evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of applicants who receive an evaluation for 1915(i) State Plan HCBS eligibility for whom there is a reasonable indication that the 1915(i) services may be needed in the future
Discovery Activity *(Source of Data & sample size)*	Review of all POC during identified time period for defensible sample of participants who were enrolled during the time period under review
Monitoring Responsibilities *(Agency or entity that conducts discoveryactivities)*	ASO

Requirement	2a) Eligibility Requirements: an evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future
Frequency	Semi-Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with ASO & CSAs/LBHAs
Frequency *(of Analysis and Aggregation)*	Based on findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

Requirement	2b) Eligibility Requirements: the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS State Plan
Discovery Activity *(Source of Data & sample size)*	Review of all POC and referral forms uploaded into the ASO's system during the identified time period for a defensible sample of participants who were enrolled
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ASO

Requirement	2b) Eligibility Requirements: the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Frequency	Semi-Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with ASO & CSAs/LBHAs
Frequency *(of Analysis and Aggregation)*	Based on findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies

Requirement	2c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually, as specified in the state plan for 1915(i) HCBS
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of participants who were re-evaluated for eligibility after one year.
Discovery Activity *(Source of Data & sample size)*	Review of authorization data for participants who were continually enrolled for one year from the sample
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ASO

Requirement	2c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually, as specified in the state plan for 1915(i) HCBS
Frequency	Semi-Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH
Frequency *(of Analysis and Aggregation)*	Based on findings, the MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

Requirement	3a) Providers meet required qualifications
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of providers who have submitted 1915(i) HCBS claims who are approved as providers by Maryland Medicaid
Discovery Activity *(Source of Data & sample size)*	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.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ASO

Requirement	3a) Providers meet required qualifications
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	If a performance improvement plan is needed, the CCO program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to BHA within 30 working days of notice of program deficiencies. The CSA/LBHA will follow up with the program 3 months after the final implementation of the performance improvement plan.

Requirement	3b) Providers meet required qualifications
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of providers who meet the initial and ongoing requirements established by MDH/BHA
Discovery Activity *(Source of Data & sample size)*	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.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ASO

Requirement	3b) Providers meet required qualifications
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	If a performance improvement plan is needed, a CCO program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to BHA within 30 working days of notice of program deficiencies. The CSA/LBHA will follow up with the program 3 months after the final implementation of the performance improvement plan.

Requirement	4) Settings meet the home and community- based setting requirements as specified in this SPA
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of youth who are dis-enrolled as a result of moving to a setting that is not authorized in this SPA
Discovery Activity *(Source of Data & sample size)*	Semi-annual sampling of entire enrolled roster
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA with the CSAs/ LBHAs

Requirement	4) Settings meet the home and community- based setting requirements as specified in this SPA
Frequency	Semi-Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	Based on the findings, the State Medicaid Agency and BHA will create a performance improvement plan within 30 working days of identification of deficiencies

Requirement	5a) The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of quarterly progress reports submitted to MDH/the State Medicaid Agency
Discovery Activity *(Source of Data & sample size)*	Quarterly reports are provided to The State Medicaid Agency by the ASO
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA

Requirement	5a) The SMA retains authority and responsibility for program operations and oversight.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA & MDH/State Medicaid Agency
Frequency *(of Analysis and Aggregation)*	Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

Requirement	5b) The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of enrollment census updates distributed to the State Medicaid Agency
Discovery Activity *(Source of Data & sample size)*	Review of distribution list for census updates issued by the ASO
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA

Requirement	5b) The SMA retains authority and responsibility for program operations and oversight.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA & MDH/State Medicaid Agency
Frequency *(of Analysis and Aggregation)*	Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

Requirement	6a) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of HCBS benefit service claims processed appropriately against fund source, authorization history, service limitations, and coding.
Discovery Activity *(Source of Data & sample size)*	Defensible sampling strategy; point in time review of services received.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/ASO

Requirement	6a) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	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 BHA within 30 working days of notice of program deficiencies. The CSA/LBHA will follow up with the program 3 months after the final implementation of the performance improvement plan. The Office of Compliance is a unit within the BHA responsible for identifying fraud and abuse, educating providers about compliance issues, and ensuring consistency with State and federal regulations. BHA 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. BHA participates with the Office of Inspector General to identify provider outliers for investigation of potential fraud and abuse.

Requirement	7) The state identifies, addresses and seeks to prevent incidents of abuse, neglect, exploitation, including the use of restraints, and unexplained deaths.
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of reportable events involving abuse, neglect, exploitation, and/or unexplained deaths reported that are resolved according to policy
Discovery Activity *(Source of Data & sample size)*	All reportable event forms are reviewed for compliance.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA

Requirement	7) The state identifies, addresses and seeks to prevent incidents of abuse, neglect, exploitation, including the use of restraints, and unexplained deaths.
Frequency	Annually, and continuously, as needed when a complaint/incident is received.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	MDH will investigate if a performance improvement plan is needed. If necessary, the program director must submit a proposal within 10 working days.

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

When data analysis reveals the need for system change, recommendations may 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.

2. Roles and Responsibilities

MDH, BHA, in conjunction with the ASO and the CSAs/LBHAs, will gather and analyze the data and identify areas for quality improvement.

3. Frequency

Annually

4. Method for Evaluating Effectiveness of System Changes

The Department or its designee 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.

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)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☑	HCBS Respite Care

COMMUNITY-BASED RESPITE CARE

Community-based respite services are provided for a minimum of one hour and a maximum of six hours per day, and may not be billed on the same day as out of home respite.

Effective July 1, 2024, a rate increase of 3% across community- based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule".

State developed fee schedule rates are the same for both governmental and private individual practitioners.

The community-based respite care rate adheres to the CMS-accepted methodology for cost-based rates which includes salary, fringe benefits, indirect costs, and transportation costs. The rate was based on the following staffing assumptions: 68% billable time, 1 FTE respite worker with a caseload of 15, 0.15 FTE administrative staff (respite supervisor at .10 FTE and administrative support at .05 FTE).

Payment for Community Based Respite Care service as outlined per Attachment 3.1-i pages 25-26 is reimbursed in accordance with the fee schedule referenced on page 57 paragraph two. Community Based Respite Care providers are defined per Attachment 3.1-i pages 26-27.

OUT OF HOME RESPITE CARE

Out of Home respite services are provided on an overnight basis for a minimum of 12 hours. 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.

Effective July 1, 2024, a rate increase of 3% across community- based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule".

State developed fee schedule rates are the same for both governmental and private individual practitioners.

The rate development was originally 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, Maryland Department of Health /Behavioral Health Administration, Department of Human Services/Social Services Administration, Department of Juvenile Services, Governor's Office for Children and the Maryland State Department of Education.

The IRC identifies programs as "preferred" or "non-preferred." The rate development was originally based on the average per diem rate for preferred programs including group homes, therapeutic group homes, and treatment foster care providers because these are comparable settings to out of home respite care.
Payment for Out Of Home Respite Care service as outlined per Attachment 3.1-i page 27- 28 is reimbursed in accordance with the fee schedule referenced on page 58 paragraph two. Out Of Home Respite Care providers are defined per Attachment 3.1-i pages 28-29.

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) – EVIDENCE BASE PRACTICES (EBP)
The approved Intensive In-Home Services (IIHS) providers will bill the Maryland Department of Health (MDH) 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.

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 two (2) face- to-face contacts are required per week. At least one of the weekly contacts must be provided in-person. The service must be provided consistent with the State approved Evidence Based Practice or State approved promising practice model. An individual can only receive IIHS services from one provider at a time. Partial hospitalization/day treatment 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 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.

Effective July 1, 2024, a rate increase of 3% across community-based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule".

The Department's reimbursement methodology for IIHS-EBP services was set as of October 1, 2014 and is effective for services on or after that date. State developed fee schedule rates are the same for both governmental and private individual practitioners.

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

- Is recognized by MDH as an EBP for youth;
  - Are derived from rigorous, scientifically controlled research; and
  - Can be applied in community settings with a defined clinical population;
- Has a consistent training and service delivery model;
- Utilizes a treatment manual; and
- 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).

Payment for Intensive In-Home service as outlined per Attachment 3.1-i pages 21-22 and is reimbursed in accordance with the fee schedule referenced on page 59 paragraph one. Intensive In-Home providers are defined per Attachment 3.1-i pages 22-24.

INTENSIVE IN-HOME SERVICES (IIHS)—NON EVIDENCE BASED PRACTICE (NON EBP)

The approved Intensive In-Home Services (IIHS) providers will bill the Maryland Department of Health 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.

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 two (2) face-to-face contacts are required per week. At least one of the weekly contacts must be provided in-person. The service must be provided consistent with the State approved Evidence Based Practice or State approved promising practice model. An individual can only receive IIHS services from one provider at a time. Partial hospitalization/day treatment 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.

Effective July 1, 2024, a rate increase of 3% across community- based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services

provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule".

The Department's reimbursement methodology for IIHS-Non EBP services was set as of October 1, 2014 and is effective for services on or after that date. State developed fee schedule rates are the same for both governmental and private individual practitioners.

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.

Payment for Intensive In-Home service as outlined per Attachment 3.1-i pages 21-22 is reimbursed in accordance with the fee schedule referenced on page 60 paragraph one. Intensive In-Home providers are defined per Attachment 3.1-i pages 22-24.

MOBILE CRISIS RESPONSE SERVICES

This service was discontinued as of 9/30/2020. Reserve for future use.

EXPRESSIVE AND EXPERIENTIAL BEHAVIORAL SERVICES

The approved expressive & experiential behavioral therapy providers will bill the Maryland Department of Health 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 expressive and experiential behavioral therapy providers will be reimbursed at the same rate.

Effective July 1, 2024, a rate increase of 3% across community-based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule".

State developed fee schedule rates are the same for both governmental and private individual practitioners.

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:

- Art Therapist certified by the Art Therapy Credentials Board in the American Art Therapy Association or licensed as a Licensed Clinical Professional Art Therapist (LCPAT)

- 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 or The Professional Association of Therapeutic Horsemanship International (PATH Int.) (Formerly the North American Riding for the Handicapped Association (NARHA))
- 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) and are reimbursed in accordance with the fee schedule referenced on page 58 paragraph six. A differential is applied for fully licensed clinicians who also have certification versus non-licensed professionals who solely possess certification in one of the expressive and experiential therapies. The group rates were based on the C&A Group Psychotherapy Rates.

Payment for Expressive and Experiential Behavioral service as outlined per Attachment 3.1-i page 33 are reimbursed in accordance with the fee schedule referenced on page 60 paragraph eight. Expressive and Experiential Behavioral providers are defined per Attachment 3.1-i page 33-36.

FAMILY PEER SUPPORT

Effective July 1, 2024, a rate increase of 3% across community-based Behavioral Health services was implemented in the agency's fee schedule and is effective for all 1915(i) services provided on or after that date. A link to the published fee schedule can be found by going to the Behavioral Health section of https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule".

State developed fee schedule rates are the same for both governmental and private individual practitioners.

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.

Payment for Family Peer Support service as outlined per Attachment 3.1-i pages 29-30 are reimbursed in accordance with the fee schedule referenced on page 61 paragraph four. Family Peer Support providers are defined per Attachment 3.1-i pages 30-33.

YOUTH PEER SUPPORT

The agency's fee schedule rate was set as of April 1, 2025 and is effective for youth peer support services provided on or after that date. A link to the published fee

		schedule can be found by going to the Behavioral Health section of https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx, clicking on "Fee Schedules", and selecting "1915(i) Fee Schedule". State developed fee schedule rates are the same for both governmental and private individual practitioners. 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. Payment for Youth Peer Support services as outlined in Attachment 3.1-i page 35 are reimbursed in accordance with the fee schedule referenced on page 62 paragraph one. Youth Peer Support providers are defined per Attachment 3.1-i pages 36-37.
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
	✔	Other Services (specify below)
		CUSTOMIZED GOODS AND SERVICES This service was discontinued as of 9/30/2020. Reserve for future use.