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State/Territory Name: Maryland

State Plan Amendment (SPA) #: 19-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
801 Market Street, Suite 9400
Philadelphia, Pennsylvania 19107

Division of Medicaid Field Operations East

SWIFT #040120194037

June 13, 2019

Dennis Schrader
Medicaid Director
Maryland Department of Health
201 West Preston Street
Baltimore, Maryland 21201

Dear Mr. Schrader:

Enclosed is a copy of the approved State Plan 1915(i) Home and Community Based Services Renewal, Transmittal Number 19-0003. The purpose of this renewal is to amend the services and eligibility requirements of the 1915(i) program to expand access to necessary behavioral health services.

The effective date for this renewal is October 1, 2019. The CMS 179 form and the Approved State Plan pages are attached.

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 18 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

If you have questions about this SPA, please contact Ms. Talbatha Myatt of my staff at 215-861-4259.

Sincerely,

/s/

Sabrina Tillman-Boyd
Acting Deputy Director

Enclosures

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: 19 — 0003

2. STATE: MD

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

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

4. PROPOSED EFFECTIVE DATE: 10/01/2019

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: N/A

7. FEDERAL BUDGET IMPACT
a. FFY 2018 $ 0
b. FFY 2019 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i pg 1-48 (19-0003)
Attachment 4.19-B pg 54-66 (19-0003)
Attachment 2.2-A pg 27-28 (19-0003)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i pg 1-48 (14-05)
Attachment 4.19-B pg 54-66 (16-0007)
Attachment 2.2-A pg 27-28 (14-05)

10. SUBJECT OF AMENDMENT
In accordance with Medicaid's proposed 1915i waiver renewal, this proposal would amend the services and eligibility requirements of the 1915i program to expand access to necessary behavioral health services.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
/s/

13. TYPED NAME
Dennis Schrader

14. TITLE
Medicaid Director
Maryland Department of Health

15. DATE SUBMITTED
March 29, 2019

16. RETURN TO
Dennis Schrader
Medicaid Director
Maryland Department of Health
20 W. Preston St, 5th Floor
Baltimore, MD 21201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
March 29, 2019

18. DATE APPROVED
June 12, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL
/s/

21. TYPED NAME
Sabrina Tillman-Boyd

22. TITLE
Acting Deputy Director

23. REMARKS

FORM CMS-179 (07/92)

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

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

***Select one*:**

X	**Not applicable**
O	**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.*	
X	The State plan HCBS benefit is operated by *(name of agency)*		
	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 under the Maryland Department of Health organizational structure. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

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):

2. The State Medicaid Agency performs eligibility evaluation in partnership with the contracted Administrative Services Organization (ASO), the Behavioral Health Administration (BHA), and the local Core Service Agency (CSA)/ Local Behavioral Health Authority.

3. The BHA, ASO, and CSA/ LBHA perform reviews of participant services plans.

4. BHA ASO

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.

8. The State Medicaid Agency and 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 and the BHA.

(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	10/1/19	9/30/20	200
Year 2			
Year 3			
Year 4			
Year 5			

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. ☑ **New 1915(i) Medicaid Eligibility Group.** In addition to providing State plan HCBS to individuals described in item 1 above, the state is also covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Attachment 2.2A, pages 27 of the State Plan).

3. **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 Administration, in conjunction with a contracted administrative services organization, and Core Services Agencies or Local Behavioral Health Authorities, the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level.

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

The 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 eligibility determination to the Department for final approval and enrollment. A licensed mental health professional will conduct the evaluation, based upon Maryland's definition of medically necessary treatment which requires services or benefits to be:

(1) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
(2) Consistent with currently accepted standards of good medical practice;
(3) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
(4) Not primarily for the convenience of the consumer, family, or provider.

The evaluator will be familiar with the medical necessity criteria and will use those criteria and the individual's clinical history to determine eligibility. The evaluator will utilize a psychosocial assessment to generate a score on the ECSII or CASII for the youth, and will compare that to the score generated by the Core Service Agency or Local Behavioral Health Authority based on the same documentation. If necessary, the evaluator will gather additional information by telephone or other means in conjunction with the CSA/LBHA.

Specific eligibility criteria, including re-evaluation criteria, are outlined in #5 below.

Once the evaluator has determined eligibility for services, a Care Coordination Organization will work with the child and family to develop an individualized Plan of Care (POC) that is consistent with the principles of Care Coordination (i.e. strengths-based, individualized, community-based, etc . The CCO will review the POC at least every 45 days, with a review by the ASO when there is a change to the POC that necessitates a pre-authorization.

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 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 3to 6 or ECSII score of 3 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 a Psychologist.) must complete or update a comprehensive psychosocial assessment within 30 days of the submission of the application to the ASO. The psychosocial assessment must outline how, due to the behavioral health disorder(s), the child or adolescent exhibits a significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, and/or community. The serious harm does not necessarily have to be of an imminent nature. The psychosocial assessment must support the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service
Intensity Instrument (CASII) for youth ages 6-21.
    a. Youth must receive a score of:
        i. 3 (moderate service intensity targeted to multiple and/or complex areas of concern that interfere with child and family functioning), 4 (High Service Intensity) or 5 (Maximal Service Intensity) on the ECSII or
        ii. 3 (intensive outpatient services), 4 (intensive integrated services without 24 hour psychiatric monitoring),5 (Non-Secure, 24-Hour, Medically Monitored Services) or 6 (Secure, 24- Hours, Medically Managed Services) on the CASII
    b. For initial evaluation youth with a score of 3-5 on the CASII also must meet one of the following criteria to be eligible based on their impaired functioning and service intensity level:
        i. Living in the community and
            • Be 6-21 years old and have 2 or more inpatient psychiatric hospitalizations or ER visits in the past 12 months or
            • Been in an RTC within the past 90 days

c. For initial evaluation youth who are younger than 6 years old who have a score of a 3-4 on the ECSII either must:
   i. Be referred 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. If living in the community, have one or more psychiatric inpatient or day hospitalizations, ER visits, 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.

2. Other Community Alternatives: The accessibility and/ or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the MDH or its designee.

3. Duplication of Services: The youth may not be enrolled in Adult Residential Program for Adults with Serious Mental Illness licensed under COMAR 1.63.01 and 10.63.04 or a Health Home while enrolled in HCBS benefit.

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	Maryland allows reimbursement to nursing homes for eligible persons who require hospital care, but who, because of their mental or	Md. Code Reg. 10.22.01.01 contains the following definitions: (2) "Alternative living unit (ALU)" means a residence	For inpatient hospital psychiatric emergency detention or involuntary admission, Md.

& 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 a Psychologist.) must complete or update a comprehensive psychosocial assessment within 30 days of the submission of the application to the ASO. The psychosocial assessment must outline how, due to the behavioral health disorder(s), the child or adolescent exhibits a significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, and/or community. The serious harm does not necessarily have to be of an imminent nature. The psychosocial assessment must support the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0- 5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-21 a. Youth must receive a score of 3, 4 or 5 on the ECSII, or 3, 4, 5 or 6 on the CASII. b. Youth with a score of 4 or less on the CASII also	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.	owned, leased, or operated by a licensee that: Provides residential services for individuals who, because of a developmental disability, require specialized living arrangements; (b) Admits not more than 3 individuals; and (c) Provides 10 or more hours of supervision per unit, per week. (25) "Group home" means a residence owned, leased, or operated by a licensee that: (a) Provides residential services for individuals who, because of a developmental disability, require specialized living arrangements; (b) Admits at least four, but not more than eight individuals; and (c) Provides 10 or more hours of supervision per week. (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; (b) Is likely to continue indefinitely;	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 (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

must meet one of the following criteria to be eligible based on their impaired functioning and service intensity level: i. Living in the community and 1. Be 6-21 years old and have 2 or more inpatient psychiatric hospitalizations or emergency room visits in the past 12 months, or 2. Been in an RTC within the past 90 days. c. Youth who are younger than 6 years old and have a score of a 3 or 4 on the ECSII either must be referred 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 if living in the community, have two or more psychiatric inpatient hospitalizations in the past 12 months. 2) Other Community Alternatives: The accessibility and/or intensity of currently available community services are inadequate		(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.	continuous assent to retention by the facility; and (5) The individual is able to ask for release

to meet these needs due to the severity of the impairment without the provision of one more of the service contained in the HCBS Benefit Duplication of Services: The youth may not be enrolled in an Adult Residential Program for Adults with Serious Mental Illness licensed under COMAR 10.21.22 or a Health Home while enrolled in the HCBS benefit.			

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) 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. Consent:
   a. Youth under 16 must have consent from the parent or legal guardian to participate; for young adults who are 16 or older and already enrolled, the young adult must consent to participate. Youth over 16 who are in the care and custody of the State, require consent from their legal guardian.
   b. The consent to participate includes information on the array and availability of services, data collection and information-sharing, and rights and responsibilities under Maryland Medical Assistance.
3. Behavioral Health Disorder:
   a. Youth must have a behavioral health disorder amenable to active clinical treatment. The evaluation and assignment of a Diagnostic and Statistical Manual (DSM) diagnosis or Diagnostic Criteria 05 (DC 0-5) must result from a face-to-face psychiatric evaluation that was completed or updated within 30 days of submission of the application to the Department or its designee

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. Because of the clinical requirement that the young person have an SED in order to be covered under the Program, the State will require the young person to be actively involved in ongoing mental health treatment on a regular basis in order to receive 1915(i) services.

☐ **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).

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 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. These are not group homes with staff providing services. A group home that is not a therapeutic or high intensity group home

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
f. Is 21 years or older; and
g. 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
h. Meets the training and certification requirements for care coordinators as set forth by the Department.
i. Is employed by the CCO to provide care coordination services to participants; and
j. 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 every 90 days by the CCO supervisor 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: identify needs to work on 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; conduct a strengths based initial assessment of the participant, their family members and potential team members. 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 45 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 45 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. The team determines the various supports and services that need to be in place for the family with the family and youth driving the process. The team is responsible to hold each other accountable in ensuring the implementation of high quality services for the family. 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 services that are authorized are consistent with the POC.

Families have access to services made available in the 1915(i) and public mental health system that will address their individualized needs, as long as they meet medical necessity criteria. Families have the primary decision making responsibility around provider selection. If a family is dissatisfied with a provider, there is an internal process within the CCO to address these needs and mediate as well as transition to another provider when needed. This includes dissatisfaction with CCOs and any other providers. 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 the needs of the family. 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 as mentioned in the prior questions.

The CCO is responsible for monitoring the implementation of plans of care by service providers. BHA will sample plans of care, review participant records, and track and trend the results of quality management activities as part of the quality assurance plan outlined below. BHA will document the results of ongoing monitoring activities on an as needed basis for reportable events reports, and annual reports, according to the quality improvement strategies, that are provided to the Medicaid Agency. The Medicaid Agency will review the quarterly and annual reports that are prepared by BHA. 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 once each week. 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 Crisis Response Services (MCRS), Mobile Treatment Services (MTS), partial hospitalization (day treatment), family therapy (not including individual therapy, medication management, or group therapy), an admission to an inpatient hospital or residential treatment center, or therapeutic behavioral services. The services provided under IIHS may not be duplicative of other Public Mental Health System or HCBS benefit services.
☑	Medically needy *(specify limits):*

	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 10.63.04	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 publically available list of practices that meet the criteria for intensive in-home services, including but not limited to Family Centered Therapy (FCT) and 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 Mental Health System or HCBS benefit services, and will not be paid on the same day as therapeutic behavioral services (COMAR 10.09.34) or any other public mental health system respite services. 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 10.63.04	Certificate from national or intermediate purveyor	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 10.21.27.04-.08 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 Mental Health System or HCBS benefit services.

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

N/A

Specify limits (if any) on the amount, duration, or scope of this service. 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	Certificate from national or intermediate purveyor	Out-of-Home Respite Care Providers must: A. Meet the out-of-home respite care requirements of COMAR 10.63.03, as determined by

	of Maryland and COMAR 10.63.04		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 10.63.04.15 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 Mental Health System or HCBS benefit services. Family peer support may be provided, and billed, for meeting with the family in-person as well as for communicating with the family over the phone. Family peer support may not be billed for telephonic communications with other providers or resources. Service limits for peer support as follows: Face to face family support limited to 11 hours per month and telephonic peer support limited to 16 hrs monthly, unless specially approved by 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):*
Family Peer Support	N/A	The National Certification for Parent Family Peers. The provider may have the certificate, be in the process of obtaining it or under the supervision of an individual	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) Submit a list of members of the

		who has the certification.	board of directors with identification that at least 50% meet the following criteria: a) Are caregivers with a current or previous primary daily responsibility for raising a child or youth with behavioral health challenges; and/or b) Are individuals who have experience with State or local services and systems as a consumer who has or had behavioral health challenges (3) Establish hiring practices that give preference to current or previous caregivers of youth with behavioral health challenges and/or individuals who have experience with State or local services and systems as a consumer who has or had behavioral health challenges, and submit a copy of the organization's personnel policy that sets forth this preferred employment criteria; (4) Employ a staff that is comprised of at least 75% individuals who are current or previous caregivers of youth with behavioral health challenges, or are individuals who have experience with State or local services and systems as a consumer who has or had emotional, behavioral health challenges, and submit a list of staff and positions held with identification of those who fit the experienced caregiver and consumer criteria; and (5) 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; (4) Have current or prior experience as a caregiver of a child with behavioral health challenges or be an individual with experience with State or local services and systems as a consumer who has or had behavioral health challenges ; and

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 three 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. The Department of Health and Mental Hygiene 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

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).

1. 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):*

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

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

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

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

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

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

●	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment 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.)

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
1) Service plans address a) assessed needs of 1915(i) participants, b) are updated annually, and c) document choice of services and providers.	a) % of participants who had a team meeting at least every 45 days b) % of participants whose plan of care (POC) was updated to include change in progress, services or other areas within ten (10) days of the team meeting	1. Defensible sample of case files (electronic or paper) of participants who were enrolled during the time period under review 2. Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review	1. MDH/BHA, with CSAs/ LBHAs 2. MDH/BHA with CSAs/ LBHAs	1. Every 12 months 2. Every 12 months	1. MDH/BHA with CSAs/ LBHAs 2. MDH/BHA with CSAs/ LBHAs	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, ASO, and CSA, as applicable, within 30 working days of notice of program deficiencies. The CSA will follow up with the program 3 months after the final implementation of the performance improvement plan.

	c) % of participants whose POC indicates they were afforded choice in the selection of services and providers	3. Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review	3. MDH/BHA with CSAs/ LBHAs	3. Every 12 months	3. MDH/BHA with CSAs/ LBHAs	

3) Providers meet required qualifications.	a) % of providers who have submitted 1915(i) HCBS claims who are approved as providers by Maryland Medicaid b) % of providers who meet the initial and ongoing requirements established by MDH/BHA	1 & 2. Defensible sampling strategy of provider files and related documentation. The sample will be drawn from providers who filed claims for services provided under the HCBS benefit during the time period under review.	1 & 2. ASO	Annually	MDH/BHA	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 will follow up with the program 3 months after the final implementation of the performance improvement plan.

4) Settings meet the home and community-based setting requirements as specified in this SPA.	1. % of youth who are dis-enrolled as a result of moving to a setting that is not authorized in this SPA.	1. Semi-annual sampling of entire enrolled roster	1. MDH/ BHA with the CSAs/ LBHAs	Semi-Annually	MDH/BHA	Based on the findings, OHS and BHA will create a performance improvement plan within 30 working days of identification of deficiencies

5) The SMA retains authority and responsibility for program operations and oversight.	a) % of quarterly progress reports submitted to MDH/Office of Health Services b) % of enrollment census updates distributed to OHS c) Medical Eligibility/enrollment Oversight	1. Quarterly reports are provided to OHS by BHA 2. Review of distribution list for census updates issued by BHA 3. Review CASII/CONS documentation	1&2. MDH/BHA 3. ASO/BHA	Annually	MDH/BHA& MDH/OHS	Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

6) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	1. % of HCBS benefit service claims processed appropriately against fund source, authorization history, service limitations, and coding. 2. % of participants with completed financial eligibility reviews in accordance with policy at initial and redetermination (to include Medical Assistance eligibility and Level of Intensity documentation).	Defensible sampling strategy; point in time review of services received.	MDH/ASO	Annually	MDH/BHA	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 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.

7) The state identifies, addresses and seeks to prevent incidents of abuse, neglect, exploitation, including the use of restraints, and unexplained deaths.	% of reportable events involving abuse, neglect, exploitation, and/or unexplained deaths reported that are resolved according to policy	All reportable event forms are reviewed for compliance.	MDH/BHA	Annually, and continuously, as needed when a complaint/incident is received.	MDH/BHA	MDH will investigate if a performance improvement plan is needed. If necessary, the program director must submit a proposal within 10 working days.

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;	Utilization review of services on POC in conjunction with provider authorization and claims data	Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review	ASO	Semi-Annually	MDH/BHA with ASO & CSAs	Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

b) The process and instruments the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately, and	Number of participants who meet all eligibility criteria.	Review of all POC and referral forms uploaded into the ASO's system during identified time period for a defensible sample of participants who were enrolled	ASO	Semi-Annually	MDH/BHA with ASO & CSAs	Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.
c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the state plan for 1915(i) HCBS.	Percent of participants who were re-evaluated for eligibility after one year.	Review authorization data for participants who were continually enrolled for one year from the sample.	ASO	Semi-annually	MDH	Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

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

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
When data analysis reveals the need for system change, recommendations 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.	MDH, BHA, in conjunction with the ASO and the CSAs, will gather and analyze the data and identify areas for quality improvement.	Annually	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. These are paid using a service unit of one hour.

Assumptions

68% billable time

Respite Care worker has caseload of 15

Hourly rate is added to hourly pay for respite care worker of $13/hour Additional $1 youth activity fee per hour is added to total

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

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services

	Annual Amount or Rate	% FTE	Salary Cost	Fringe Benefits (30%)	Salary + Fringe Cost
Respite Supervisor	$50,000.00	0.10	$5,000.00	$1,500.00	$6,500.00
Admin. Support	$35,000.00	0.05	$1,750.00	$525.00	$2,275.00
Total		0.15	$6,750.00	$2,025.00	$8,775.00

Other Costs (based on FTE)		
Rent (144 Square Feet @ $15 per square foot per FTE)	$	324.00
Cellular Phone, Internet & Communications (@$110/month per FTE)	$	198.00
Mileage (10,000 miles per year @ $0.555/mile)	$	5,550.00
Insurance (general liability, professional liability) @$1,000 per FTE	$	150.00
Indirect Cost (7% of salaries)	$	472.50
Total cost for 1 FTE respite care worker	$	15,469.50
Hourly Rate--Not Including Respite Care Worker (Based on 1386	$	11.16
Hourly Rate for Administration + Respite Care Worker + $1		
Activity Fee	$	25.16

State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the schedule are published at the above website address.

OUT OF HOME RESPITE CARE

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

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

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

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

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

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

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address

For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☑	HCBS Psychosocial Rehabilitation

Intensive In-Home Services (IIHS) – EBP

Personnel	Annual Amount or Rate	% FTE	Salary Cost	Fringe Benefits (25%)	Salary + Fringe Cost
Therapist	$ 50,000	1	$ 50,000	$ 12,500	$ 62,500.00
Supervisor/Clinical Lead	$ 75,000	0.20	$ 15,000	$ 3,750	$ 18,750.00
Clinical Director	$ 100,000	0.09	$ 9,000	$ 2,250	$ 11,250.00
Quality Assurance/Management Info. Systems Director	$ 90,000	0.09	$ 8,100	$ 2,025	$ 10,125.00
Admin. Assistant	$ 35,000	0.25	$ 8,750	$ 2,188	$ 10,937.50
Billing Support Specialist	$ 35,000	0.05	$ 1,750	$ 438	$ 2,187.50
Total		1.68	$ 92,600	$ 23,150	$ 115,750

Rent ($15/sq ft, 144 sq ft per FTE)	
Cellular Phone, Internet & Communications (@$110/month per FTE)	$ 2,217.60
Office supplies and maintenance (paper, postage, pens, printing, copier/fax) @ $750 per FTE	$ 1,260.00
Mileage (20,000 miles per year @ $0.555/mile)	$ 11,100.00
Management Information System @$150 per FTE	$ 252.00
Insurance (general liability, professional liability) @ $1,000 per FTE	$ 1,680.00
Indirect Cost (7% of salaries)	$ 6,482.00
Total Cost for 1 FTE Therapist	**$ 142,370.40**
Weekly rate (Total Cost/52 weeks/11 clients)	**$ 248.90**

Assumptions:

Supervisor caseload of 5 therapists

Maximum length of service is 16 weeks

Intensive In-Home Services (IIHS) providers may be reimbursed at a regular weekly rate of service. The approved IIHS providers will bill the 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.

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

experience with programs similar to IIHS in Maryland, including the salaries paid.

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

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

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

The rate is higher for those programs that are identified as an EBP, in keeping with the established practice of different reimbursement rates for an EBP versus non-EBP service (e.g., Mobile Treatment Services and Assertive Community Treatment).

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

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

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

Intensive In-Home Services (IIHS)- NON EBP

Personnel	Annual Amount or Rate	% FTE	Salary Cost	Fringe Benefits (25%)	Salary + Fringe Cost
Therapist	$ 50,000	0.50	$ 25,000	$ 6,250	$ 31,250.00
Supervisor/Clinical Lead	$ 75,000	0.20	$ 15,000	$ 3,750	$ 18,750.00
In-Home Stabilizer	$ 40,000	0.50	$ 20,000	$ 5,000	$ 25,000.00
Clinical Director	$ 100,000	0.08	$ 8,000	$ 2,000	$ 10,000.00
Admin. Assistant	$ 35,000	0.25	$ 8,750	$ 2,188	$ 10,937.50
Billing Support Specialist	$ 35,000	0.05	$1,750	$ 438	$ 2,187.50
Total		1.58	$78.500	$19,625	$ 98,125

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

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

Intensive In-Home Services (IIHS) providers may be reimbursed at a regular weekly rate of service. The approved IIHS providers will bill the 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.

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

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

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

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

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

EXPRESSIVE AND EXPERIENTIAL BEHAVIORAL SERVICES

Proposed Rates

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

LMHP=Licensed Mental Health Practitioner

Rates from FY13 PMHS:	
45-50 minute rate for an individual clinician in the PMHS, FY 13	62.19
75-80 minute rate for C&A Prolonged Psychotherapy	80.85
45-60 minute rate for C&A group psychotherapy	27.2
Prolonged rate for C&A Group Psychotherapy	35.36

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

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

- 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 North American Handica
- Horticultural Therapist Registered by The American Horticultural Therapy Association
- Music Therapist-Board Certified by the Board for Music Therapists, Inc in the American Association for Music Therapy, Inc.
- Registered Drama Therapist or Board Certified Trainer in the National Association for Drama Therapy

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

Expressive and experiential behavioral therapy service providers who are licensed mental health professionals (licensed certified social worker-clinical, nurse psychotherapist, licensed clinical professional counselor, licensed clinical marriage and family therapist, and certified registered nurse practitioner-psychiatric) are reimbursed for this service at a rate that is 10% greater than the standard rate for non-mental health licensed professionals providing the same service. A differential was selected based on the additional costs to providers to obtain and maintain their license and the cost of and time required to obtain continuing education credits.

In the 1915(c) PRTF Demonstration Waiver (RTC Waiver), it was difficult to 1) Ascertain how many of the expressive and experiential behavioral service providers were also licensed mental health clinicians and 2) encourage licensed mental health clinicians who were already Public Mental Health System providers to enroll to provide the additional service (a necessary step in helping families and youth to identify the most appropriate provider to address their needs). As a result, the high rate was developed to address both of these issues through a mechanism to encourage provider enrollment and more accurately track provider utilization. The group rates were set based on

the C&A Group Psychotherapy Rates.

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

The agency's fee schedule was set as of October 1, 2014 and is effective for service provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-

State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

FAMILY PEER SUPPORT

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

Billable Time		
Family Support Partner	2080	Total work hours per year (8 hour day * 260
Family Support Partner Supervisor		
Administrative Assistant	160	Vacation, sick & holiday leave: 20 days@8
Billing Support Specialist	128	Training: 16 days @8hours per day
Administrator	440	Travel (not with client): 10 hours per week
Total	**728**	Total Non-Billable Time
	1352	Total Projected Billable Time
	0.35	% Non-Billable

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

Hourly rate	**$ 63.88**
30 minute rate	**$ 31.94**
15 minute rate	**$ 15.97**
15 minute telephonic/non-face-to-face rate	**$ 7.98**

Assumptions:
*Supervisor: FSP ratio is 1:10

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

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

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

Payment for Family Peer Support service as outlined per Attachment 3.1-i page 26- 27 and is reimbursed a fifteen minute unit of service. Family Peer Support providers are defined per Attachment 3.1-i page 27-29.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

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

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☐ No. Does not apply. State does not cover optional categorically needy groups.

☑ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☑ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☑ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

For groups in the state plan home and community-based services group under 42 CFR 42 CFR § 435.219 only, after SSI countable income, the State disregards income in the amount of the difference between 150% of the Federal Poverty Level and 300% of the Federal Poverty Level.

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

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

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.