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Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Maryland

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation 3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, as defined in 42 CFR 440.165 are provided to the extent that nurse-midwives are authorized to practice under State law or regulation. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

/ / Not applicable. Nurse-midwives are not authorized to practice in this State.

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Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(X) (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10), clause (VII) of the matter following (E) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

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Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

(vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.

1902(e)(7) of the Act

(vii) Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

1902(e)(9) of the Act

/7 (viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1902(a)(52) and 1925 of the Act

(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

TN No. 92-11
Supersedes TN No. _____

Approval Date JUN 05 1992

Effective Date NOV 0 1 1991

HCFA ID: 7982E

State of Maryland
PACE State Plan Amendment

Citation 3.l(a)(l) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(26) and 1934
X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage - that is in excess of established service limits-for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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August 1991

State/Territory: Maryland

Citation

3.1 Amount, Duration and Scope of Services (continued):

42 CFR Part 440, Subpart B

(a)(2) Medically needy.

[X] This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902 (a) (10) (C) (iv) of the Act
42 CFR 440.220

(i) If services in an institution for mental diseases (42 CFR of the Act 440.140 and 440.160) or an intermediate care facility for 42 CFR 440.220 the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a) (l) through (5) and (17) of the Act, or seven of the services listed in section 1905(a) (l) through (20). The services are provided as defined in 42 CFR Part 440 Subpart A and in sections 1902, 1905, and 1915 of the Act.

[ ] Not applicable with respect to nurse-midwife services under section 1902(a) (17). Nurse-midwives are not authorized to practice in this State.

1902(e) (5) of the Act

(ii) Prenatal care and delivery services for pregnant women.

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AUGUST 1991

State/Territory: Maryland

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/X/ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

/ / Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, 440.160
Subpart B, 442.441, Subpart C
1902(a)(20) and (21) of the Act

/X/ (vii) Services in an institution for mental diseases for individuals over age 65..

/X/ (viii) Services in an intermediate care facility for the mentally retarded.

/ / (ix) Inpatient psychiatric services for individuals under age 21.

TN No. 92-11
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Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Maryland

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of the Act

/7 (ix) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State of Maryland
PACE State Plan Amendment

Citation 3.1 (a)(2) Amount, Duration and Scope of Services: Medically Needy (continued)

1905(a)(26) and 1934

_X_ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1 –A.

ATTACHMENT 3.1 -B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage - that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Revision: HCFA-PM-97-3 (CMSO)
December 1997
State: Maryland

Citation		
	3.1	Amount, Duration, and Scope of Services (continued)
	(a) (3)	Other Required Special Groups: Qualified Medicare Beneficiaries
1902 (a) (10) (E) (I) and clause (VIII) if the matter following (F), and 1905 (p) (3) of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in section 1905 (p) of the act is provided only as indicated in item 3.2 of this plan.
1902 (a) (10) (E) (ii) and 1905 (s) of the Act	(a) (4) (I)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902 (a) (10) (E) (ii) of the Act are provided as indicated in item 3.2 of this plan.
1902 (a) (10) (E) (iii) and 1905 (p) (3) (A) (ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902 (a) (10) (E) (iii) of the Act are provided as indicated in item 3.2 of this plan.
1902 (a) (10) (E) (iv) (I) and 1905 (p) (3) (A) (ii), and 1933 of the Act	(iii)	Other Required Special Groups: Qualifying Individuals Medicare Part B premiums for qualifying individuals described in 1902 (a) (10) (E) (iv) (I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

TN No. 98-5
Supersedes TN No. 93-22 Approval Date APR 2 1 1998 Effective Date 1/1/1998

Revision: HCFA-PM-97-3 (CMSO)
December 1997
State: Maryland

1925 of the Act

(a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Maryland

Citation		
	3.1(a)(6)	Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902(a) and 1903(v) of the Act	(iii)	Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
		Presumptively Eligible Pregnant Women
1902(a)(47) and 1920 of the Act	(a)(8)	Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

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Supersedes TN No. ____
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Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Maryland

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 /_/ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

42 CFR 440.240 and 440.250 (a)(10) Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), and 1925(b)(4) of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

/_/ (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

Revision: HCFA-AT-80-33 (BPP)
May 22, 1980

State Maryland

Citation
42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☑ Yes

☐ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

☑ Yes, to all

☐ Yes, to individuals age 21 or over; SNF services are provided

☐ Yes, to individuals under age 21; SNF services are provided

☐ No; SNF services are not provided

☐ Not applicable; the medically needy are not included under this plan

Revision: HCFA-PM-93-8 (BPD)
December 1993

State/Territory: Maryland

Citation

3.1 Amount, Duration and Scope of Services (continued):

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1A Item 24.a. and ATTACHMENT 3.1-D

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation		
42 CFR 440.260 AT-78-90	3.1(d)	Methods and Standards to Assure Quality of Services The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	Family Planning Services The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

Revision: HCFA-PM-87-5 (BERC) OMB No: 0938-0193
April 1987

State/Territory: Maryland

Citation
42 CFR 441.30
AT-78-90

3.1 (f)(1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

[X] Yes

[ ] No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

[ ] Not applicable. The conditions in the first sentence do not apply.

1903 (i) (1) of the Act, P.L. 99-272 (Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

[ ] No.

[X] Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Maryland

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act, P.L. 99-509 (Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

/ / 30 consecutive days;

/ / ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/ / Yes. The requirements of section 1902(e)(9) of the Act are met.

/X/ Not applicable. These services are not included in the plan.

Revision: HCFA-PM-91-1991 (MB)

State/Territory: Maryland

Citation		
1905(a)(24) and 1930 of the Act P.L. 101-508 (Section 4712 OBRA 90)	3.1(i)	Community supported living arrangements services

Community supported living arrangements services provided to developmentally disabled individuals in accordance with section 1930 of the Act.

___ Yes.

X No.

Attachment 3.1-F identifies the community supported living arrangements services provided.

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: Maryland

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A and also for individuals dually eligible both as QMB's and Medicaid categorically or medically needy, by the following method:

____ Group premium payment arrangement for Part A

_X_ Buy-In agreement for

_X_ Part A _X_ Part B

____ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3 (CMSO)
December 1997
State: Maryland

Citation		
1902(a)(10) (E)(ii) and 1905(s) of the Act	(ii)	Qualified Disabled and Working Individual (QDWI) The Medicaid agency pays Medicare Part A premiums under the State buy-in process subject to any contribution required as described in ATTACHMENT 4.18-F., for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iii) and 1905 (p)(3)(A)(ii) of the Act	(iii)	Specified Low-Income Medicare Beneficiary (SLMB) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.
1902 (a)(10)(E)(iv)(I), 1905 (p)(3)(A)(ii), and 1933 of the Act	(iv)	Qualifying Individual – 1 (QI-1) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902 (a)(10)(E)(iv)(I) and subject to 1933 of the Act.

Revision: HCFA-PM-97-3 (CMSO)
December 1997
State: Maryland

Citation

1843 (b) (and 1905 (a) of the Act and 42 CFR 431.625

(v) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI): b) receiving State supplements under title XVI: or c) within a group listed at 42 CFR 431.625 (d)(2).

Individuals receiving title II or Railroad Retirement benefits.

Medically needy spend-down and medically needy non—QMB eligible individuals (FFP is not available for this group).

1902 (a)(30) and 1905 (a) of the Act

(2) Other Health Insurance

____ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: Maryland

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a),and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

___ For the entire range of services available under Medicare Part B.

___ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

Revision: HCFA-PM-91-8 (MB)
October 1991

OMB No.:

State/Territory: Maryland

Citation		Condition or Requirement
1906 of the Act	(c)	Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid co-payment) for eligible individuals in employer-based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h). ☐ Yes ☒ No
1902(a)(10)(F) of the Act	(d)	☐ The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State Maryland

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Maryland

Citation		
42 CFR 441.252 AT-78-99	3.4	Special Requirements Applicable to Sterilization Procedures All requirements of 42 CFR Part 441, Subpart F are met.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: Maryland

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

☒ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☐ Medical or remedial care provided by licensed practitioners.

☐ Home health services.

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Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

- ☐ Private duty nursing services.
- ☐ Physical therapy and related services.
- ☐ Other diagnostic, screening, preventive, and rehabilitation services.
- ☐ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- ☐ Intermediate care facility services for the mentally retarded.
- ☐ Inpatient psychiatric services for individuals under age 21.
- ☐ Hospice services.
- ☐ Respiratory care services.
- ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

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Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

☐ 1st 6 months ☐ 2nd 6 months

☐ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

☐ 1st 6 mos. ☐ 2nd 6 mos.

(d) ☐ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a State employee health plan.

☐ Enrollment in the State health plan for the uninsured.

☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

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Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ☐ No limitations ☒ With limitations*

2. a. Outpatient hospital services.

   Provided: ☐ No limitations ☒ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the state plan.

   Provided: ☐ No limitations ☒ With limitations*

   ☐ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

   Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ☐ No limitations ☒ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of child-bearing age.

Provided: ☒ No limitations ☐ With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ☐ No limitations ☒ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ☐ No limitations ☒ With limitations*

* Description provided on attachment.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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

a. Podiatrists' services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

b. Optometrists' services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Chiropractors' services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

d. Other practitioners' services.

[X] Provided Identified on attached sheet with description of limitations, if any.

[ ] Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: [ ] No limitations [X] With limitations*

b. Home health aide services provided by a home health agency.

Provided: [ ] No limitations [X] With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

_x_ Provided: ___No limitations _x_ With limitations*
___ Not Provided.

e. Newborn early discharge assessment visit.
_x_ Provided: ___ No limitations _x_ With limitations*
___ Not Provided.

8. Private duty nursing services.
_x_ Provided: ___ No limitations _x_ With limitations*
___ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY REEDY

9. Clinic services.
/X / Provided: / / No limitations /X / With limitations*
/ / Not provided.

10. Dental services.
/X / Provided: / / No limitations /X / With limitations*
/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X / Provided: / / No limitations /X / With limitations*
/ / Not provided.

b. Occupational therapy.

/X / Provided: / / No limitations /X / With limitations*
/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X / Provided: / / No limitations /X / With limitations*
/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. **Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

a. **Prescribed drugs.**

/X/ **Provided:** // **No limitations** /X/ **With limitations***
// **Not provided.**

b. **Dentures.**

/X/ **Provided:** // **No limitations** /X/ **With limitations***
// **Not provided.**

c. **Prosthetic devices.**

/X/ **Provided:** // **No limitations** /X/ **With limitations***
// **Not provided.**

d. **Eyeglasses.**

/X/ **Provided:** // **No limitations** /X/ **With limitations***
// **Not provided.**

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

a. **Diagnostic services-**

/X/ **Provided:** // **No limitations** /X/ **With limitations***
// **Not provided.**

***Description provided on attachment.**

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

State/Territory: Maryland

b. Screening services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Preventive services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

a. Inpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Nursing facility services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on attachment

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

State/Territory: Maryland

15. Intermediate care facility services in a public institution (or distinct part therof) for the Intellectually Disabled or persons with related conditions.

[X] Provided: [ ] No limitations [X] With limitations*
[ ] Not provided.

16. Inpatient psychiatric facility services for individuals under 21 years of age.

[X] Provided: [ ] No limitations [X] With limitations*
[ ] Not provided

17. Nurse-midwife services.

[X] Provided: [ ] No limitations [X] With limitations*
[ ] Not provided.

18. Hospice care (in accordance with section 1905(o)) of the Act.

[X] Provided: [ ] No limitations [X] With limitations*
[ ] Not provided.

* Description provided on attachment

State/Territory: Maryland

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

[X] Provided: [X] With limitations*
[ ] Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

\+ ++
[X] Provided: [ ] Additional coverage

b. Services for any other medical conditions that may complicate pregnancy.

\+ ++
[X] Provided: [ ] Additional coverage
[ ] Not Provided.

c. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy to individuals covered under section 1902(a) (10) (A) (ii) (IX) of the Act.

\+ ++
[X] Provided: [ ] Additional coverage
[ ] Not Provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: Maryland

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

[X] Provided: [ ] No limitations [X] With limitations*
[ ] Not provided.

b. Services of Christian Science nurses.

[ ] Provided: [ ] No limitations [ ] With limitations*
[X] Not provided.

*Description provided in attachment.

State/Territory: Maryland

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

c. Care and services provided in Christian Science sanatoria.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*See Attachment 3.1A Item 4a page 14 for limitations

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Billing Limitations only on Attachment 4.19B Preface page 2

f. Personal care services in recipient's home prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

g. Nurse Anesthetist services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

h. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

State/Territory: Maryland

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Reserve for future use

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1A.

☒ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

☐ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan services.

*Description provided on attachment.

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: [X] No limitations With limitations None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: [X] No limitations With limitations (please describe below)

Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

[X] (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

STATE PLAN FOR MEDICAL ASSISTANCE
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STATE OF MARYLAND

ENHANCED SERVICES FOR PREGNANT AND POSTPARTUM RECIPIENTS

Under the authority of section 1902(a) (10) (E), making available enriched services relating to pregnancy (including prenatal, pregnant and delivery, or postpartum services) or to any other condition which may complicate pregnancy. The services are available to a pregnant recipient or postpartum recipient who is certified for and is receiving Medical Assistance benefits, enters the Healthy Start Program during a medically verified pregnancy or up to 60 days after the delivery, may continue in the program receiving postpartum-family planning services up to 60 days after the delivery, and elects to receive Healthy Start services.

ENHANCED SERVICES FOR PREGNANT AND POSTPARTUM RECIPIENTS

Definition of Services:

Healthy Start Program means a program designed to identify and address medical, nutritional, and psychosocial predictors of poor birth outcomes and poor child health by providing enhanced prenatal and postpartum services for pregnant and postpartum female recipients and enhanced follow-up services to identify high- risk infant and child recipients.

I. Risk Assessment - Plan of Care means a package of services provided to a pregnant participant by or under the supervision of a physician or nurse-midwife in conjunction with the clinical services provided by the physician or nurse-midwife. One unit of service is to be reimbursed for each pregnancy. The services include:

   a. A Risk Assessment is a comprehensive appraisal of the participant's medical history and current health, nutritional, psychological, and social status, as specified in the Healthy Start Risk Assessment Instrument.

   b. A Plan of Care is a description of the services and resources required to meet the participant's needs identified through the risk assessment.

2. Enriched Maternity Service means direct counseling, educational, case coordination, and referral services provided to all pregnant or postpartum recipients by or under the supervision of a physician or certified nurse-midwife in conjunction with the clinical services provided by the physician or nurse-midwife during each prenatal or postpartum visit.

   The following components comprise Enriched Maternity Service:

   a. Prenatal and postpartum counseling and health education for all pregnant and postpartum participants.

   b. Nutrition education for all pregnant and postpartum participants including the benefits of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

   c. Case coordination and referral for all pregnant participants.

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

Remote Patient Monitoring

The purpose of providing remote patient monitoring services is to assist in the effective monitoring and management of patients whose medical needs can be appropriately and cost-effectively met at home through the application of remote patient monitoring intervention.

Remote Patient monitoring services use a synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient in the home; this information is then transmitted to a provider for use in treatment and management of unstable/uncontrolled medical conditions that require frequent monitoring.

Eligible conditions are congestive heart failure, diabetes and chronic obstructive pulmonary disease. Remote patient monitoring services are based on medical necessity and should be discontinued when the patient's condition is determined to be stable/controlled.

Eligible participants must have a eligible condition and one of the following qualifying medical events: (1) Two hospital admissions within the prior 12 months with the same qualifying medical condition as the primary diagnosis for both episodes; (2) Two emergency department visits within the prior 12 months with the same qualifying medical condition as the primary diagnosis for both episodes; or (3)1 hospital admission and 1 separate emergency department visit within the prior 12 months with the same qualifying medical condition as the primary diagnosis for both episodes.

Remote patient monitoring services may be provided by a physician, nurse practitioner, physician assistant or a home health agency when prescribed by a physician who has examined the patient and with whom the patient has an established, ongoing relationship.

All remote patient monitoring services must be performed on a dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by remote patient monitoring, including the actual transmission of health care data and any other electronic information/records.

Limitations

The Department will only cover:

1. Participants meeting the eligibility requirements stated above;
2. RPM services that receive prior-authorization from the Department;
3. Two months per episode of treatment; and
4. Two episodes per year per participant.

Home health agencies will only be reimbursed for remote patient monitoring when the service is ordered by a physician.

Reserved for future use

STATE PLAN FOR MEDICAL ASSISTANCE
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STATE OF MARYLAND

Description of Services: INPATIENT SERVICES

Medically necessary services that require admission in an acute or chronic hospital.

Provider Types:

"Hospital" refers to Maryland Licensed institutions that meet the standards of 42 CFR §440.10.

Limitations:

Reimbursement will not be made for any services identified by the Department as not medically necessary or not covered.

Authorization by the Department or its designee is required for all non-emergent admissions except deliveries. If a vaginal delivery exceeds 2 days or a cesarean section delivery exceeds 4 days, authorization is required for subsequent inpatient days through the date of discharge.

Concurrent review is also required for all hospital stays for Medicaid participants.

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2.a **Description of Services**: OUTPATIENT SERVICES

Medically necessary services that are diagnostic, curative, palliative, or rehabilitative treatment that are available in an acute, chronic, or psychiatric hospital but that do not medically necessitate admission.

Provider Types:

"Hospital" refers to Maryland Licensed institutions that meet the standards of CFR §440.20(a).

Limitations

Includes but is not limited to:

- Any service not medically necessary.
- Sterilizations if not performed according to criteria contained in 42 C.F.R. §441.250-441.259, and if the appropriate Departmental forms, as established by guidelines, are not properly completed.
- Services or drugs that are experimental or investigational.
- Immunizations for travel.

Preauthorization is required for Mental health services.

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2.a-1. Provider-Based Outpatient Oncology Facilities

A. Outpatient Oncology Facilities cover medically necessary facility services rendered to recipients in a free-standing Medicare-certified clinic including which are medically necessary, defined as diagnostic, curative, palliative, or rehabilitative services, when clearly related to the recipient's individual needs; and include:

(1) Radiation Therapy;
(2) Chemotherapy;
(3) IV Infusion;
(4) Blood transfusions;
(5) Medical supplies;
(6) Drugs; and
(7) Bone marrow biopsies

B. Specific requirements for participation in the Program as a Medicare-certified provider based outpatient oncology facility include all of the following:

(1) Be a Medicare-certified facility;
(2) Have clearly defined, written patient care policies; and
(3) Maintain adequate documentation of each recipient visit as part of the plan of care which at a minimum, shall include:

a) Date of service;
b) A description of the service provided; and
c) A legible signature and printed or typed name of the professional providing care, with the appropriate title;

C. Limitations
The following services are not covered:

(1) Any service or treatment that is not medically necessary;
(2) Experimental or investigational services;
(3) Services that are specifically included as part of another service; and
(4) Professional fees provided by physicians billed separately from the facility's charges.

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2.b **Description of Services**: RURAL HEALTH CENTER SERVICES

Mandatory services/visits are provided in accordance with 42 CFR 440.230 per recipient. There are exceptions to visit limitations. Additional visits may be authorized if the visit is medically necessary.

Provider Types

Provider types may include: Physicians, Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, Clinical Social Workers, Clinical Psychologists, RNs, and other ambulatory services otherwise approved in the State Plan.

Limitations

- Services not medically necessary;
- Investigational and experimental drugs and procedures;
- Cosmetic procedures, unless preauthorized;
- Separate reimbursement to a physician for services provided in a free-standing clinic in addition to the free-standing clinic reimbursement; and
- Payment for more than one visit to complete an EPSDT screening service.

STATE PLAN FOR MEDICAL ASSISTANCE
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2.c. **Description of Services:** FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Mandatory services/visits are provided in accordance with 42 CFR 440.230 per recipient. There are exceptions to visit limitations. Additional visits may be authorized if the visit is medically necessary.

Provider Types

Provider types may include: Physicians, Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, Clinical Social Workers, Clinical Psychologists, RNs, and other ambulatory services otherwise approved in the State Plan.

Limitations

- Services not medically necessary;
- Investigational and experimental drugs and procedures;
- Cosmetic procedures, unless preauthorized;
- Separate reimbursement to a physician for services provided in a free-standing clinic in addition to the free-standing clinic reimbursement; and
- Payment for more than one visit to complete an EPSDT screening service

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3.a **Description of Services**: X-RAY (RADIOLOGY) SERVICES

Services that utilize imaging to visualize areas within the human body.

Provider Types:

Free standing diagnostic radiology facilities that perform imaging services and meets the standards outlined in CFR §440.30.

Limitations:

Includes:

- Procedures are investigational or experimental in nature;
- Services included by the Program as part of the charge made by an inpatient facility, hospital outpatient department, freestanding clinic, or other Program-recognized entity;

3.b **Description of Services**: LABORATORY SERVICES

Laboratory Services provides for the examination of material derived from the human body, by means of one or more of the scientific disciplines for the purpose of obtaining scientific data that may be used to determine the presence, source, progress, or identity of disease agents and to aid in the prevention, diagnosis, treatment, and management of human disease.

Provider Types:

Medical laboratory means a CLIA certified and licensed facility operated for the examination of material derived from the human body, by means of one or more of the scientific disciplines.

Reference laboratory means a medical laboratory, which is enrolled with the Program as either a provider or a renderer, to which a medical laboratory provider refers specimens from Medical Assistance recipients for analysis.

Referring laboratory means a medical laboratory provider that refers specimens from Medical Assistance recipients for analysis.

Limitations:

The following are not covered:

- Procedures which are investigational or experimental in nature;
- Any service not medically necessary
- Services included by the Program as part of the charge made by an inpatient facility, hospital outpatient department, freestanding clinic, or other Program-recognized entity;
- Medical laboratory services for which there was insufficient quantity of specimen, improper specimen handling, or other circumstances that would render the results unreliable.

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4a. Nursing facility services (other than in institutions for mental diseases)

- "Nursing facility services (other than in institutions for mental diseases)" means services provided to individuals for whom the Department or its designee has determined that (1) nursing care and related services, (2) rehabilitation services, or (3) on a regular basis, health-related services above the level of room and board.

- Services are provided in facilities that fully meet the requirements for a State license to provide nursing facility services.

- Limitations. The following are not covered:

  - Services for which payment is made directly to a provider other than the nursing facility.

  - Administrative days not approved by the Department or its designee.

  - Audiology services.

STATE PLAN FOR MEDICAL ASSISTANCE
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PROGRAM	LIMITATIONS
4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	1. PURSUANT TO 42 CFR §441.50 et seq., as amended, any limits on services or treatments in other sections of the State Plan are not applicable for individuals under 21 years when it is shown that the treatment of services is medically necessary to correct or ameliorate defects and physical and mental illnesses. 2. For all services included in this section of the State Plan, the following services are not covered: a. Services not medically necessary; or b. Investigational, experimental, or ineffective services, devices or both; 3. EPSDT screening and treatment providers shall meet all of the licensure and certification requirements specified in State and Federal regulations, statute, or policy for the service that the provider renders. In order for the Program to consider a health care practitioner for certification by the Healthy Kids Program as an EPSDT screening provider, the practitioner shall have a demonstrated history of providing services to children younger than 21 years old and shall also: a. Be a doctor of medicine or doctor of osteopathy who is: (i) Licensed in good standing and (ii) Legally authorized to practice medicine and or surgery in the jurisdiction

STATE PLAN FOR MEDICAL ASSISTANCE
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PROGRAM	LIMITATIONS
4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	in which the service is provided; and (iii) Board certified in pediatrics, family practice, or internal medicine; or b. Be a pediatric or family nurse practitioner or a physician assistant who is licensed in good standing and certified to practice in the jurisdiction in which services are provided: or c. Be a freestanding clinic that employs or contracts with one or more of the licensed health care practitioners listed in a or b. (i) A freestanding clinic means a health care facility that is not licensed as a hospital, part of a hospital, or nursing home and is not administratively part of a physician's, dentist's, or osteopath's office, but has a separate staff functioning under the direction of a clinic administrator or health officer and is operated to provide ambulatory health services. (ii) A freestanding clinic does not include a clinic or clinic site located in a participant's home. 4. Any health care practitioner whose professional services are recognized in § 1905(a) of the Social Security Act may apply to the Program to be an EPSDT partial or interperiodic screening provider and EPSDT treatment provider. 5. EPSDT participants are generally limited to one EPSDT comprehensive well-child screen for each age interval specified by the Maryland Healthy Kids Preventive Health Schedule. However, the Program allows additional screening as deemed necessary. The Maryland Healthy Kids Preventive Health Schedule reflects minimum standards

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PROGRAM	LIMITATIONS
4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	for screenings and assessments required for all Maryland Medicaid recipients from birth to 21 years of age. The Maryland Healthy Kids Program requires yearly preventive care visits between ages 3 years through 20 years. 6. Vision services including eye examinations and eyeglasses or contact lenses are generally limited to no more than once a year, following a referral from an EPSDT screening provider or a physician or optometrist who has performed an equivalent screening. These limitations can be waived based on medical necessity. Please see pages 18- 19 and pages 29 through 29C of 3.1A for detailed description of all vision service limitations. 7. Initial and periodic dental examinations are generally limited to two per patient per 12-month period. This can be waived based on medical necessity. Please see pages 23 to 23E for detailed descriptions of all dental service limitations. 8. Audiological services are generally limited to one audiological evaluation per year. This can be waived based on medical necessity. Please see page 24B for detailed description of all audiology/ hearing aid service limitations.

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PROGRAM	LIMITATIONS
4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	9. To participate in the Maryland Medical Assistance Program as a medical day care for medically fragile and technology dependent children and therapeutic nursery services, a provider shall: a. Gain approval by the EPSDT screening provider every 6 months for continued treatment. This approval must be documented by the EPSDT screening provider and the EPSDT referred services provider in the recipient's medical record; and b. Have experience rendering services to individuals from birth to 21 years old.

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PROGRAM	LIMITATIONS
4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	10. To participate in the Maryland Medical Assistance Program as an EPSDT referred services provider for intermediate alcohol and drug treatment facilities and other necessary health care services described in section 1905(a) of the Social Security Act, a provider shall: a. Gain approval by EPSDT screening provider every 30 days for continued treatment. This approval must be documented by the EPSDT screening provider and the EPSDT referred services provider in the recipient's medical record; and b. Have experience rendering services to individuals from birth to 21 years old. services provider in the recipient's medical record; and

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STATE PLAN PROGRAM
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF MARYLAND

PROGRAM	LIMITATIONS
(Continued) 4.B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	11. To participate in the Maryland Medical Assistance Program as an EPSDT School Health-Related Services or Health-Related Early Intervention Services provider, a provider shall: a. At a minimum, gain annual approval by the multidisciplinary team which develops the recipient's Individualized Family Service Plan or Individualized Education Program for continued treatment; and b. Have experience with rendering services to individuals from birth to 21 years.

STATE PLAN FOR MEDICAL ASSISTANCE UNDER
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STATE OF MARYLAND

Program	Limitations
(Continued) 4.B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	Private Duty Nursing Services A. Private Duty Nursing Services are nursing services provided to qualified individuals how are under age 21. Services are provided in a participant's own home or another setting when normal life activities take the participant outside his or her home except for limitations described in Section D below. B. Covered services include: (1) An initial assessment of a participant's medical need for private duty nursing by a licensed registered nurse; and (2) On-going private duty nursing and supervisory service. To be a covered service, direct care nursing must be: (1) Ordered by the participant's primary medical provider (Orders must be renewed every 60 days); (2) Provided in accordance with a Plan of Care; (3) Provided under the supervision of a registered nurse by: (a) A registered nurse; or (b) A licensed practical nurse; (4) Provided by individuals with a current certification in CPR; (5) Of a complexity, or the condition of the participant must require, the judgment, knowledge, and skills of a registered nurse, licensed practical nurse,; and, (6) Of a scope that is more individual and continuous than nursing available under the Home Health Program

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Program	Limitations
(Continued) 4.B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	C. On-going private duty nursing services, with the exception of those services that are preauthorized through the Individualized Education Program (IEP)/Individual Family Services Plan (IFSP) process, must be preauthorized by the Medicaid Program D. Private Duty Nursing services does not include: (1) Part time/intermittent nursing services covered as Home Health Services; (2) Nursing Services rendered by a nurse, who is a member of the participant's immediate family or who ordinarily resides with the participant; (3) Custodial service; (4) Services not deemed medically necessary at the time of the initial assessment or plan of care review; (5) Services delivered by a licensed nurse who is not directly supervised by a licensed registered nurse who documents all supervisory visits and activities; (6) Services provided to a participant in a hospital, residential treatment center, intermediate care facility for individuals with intellectual disabilities or a residence or facility where private duty nursing services are included in the living arrangement by regulation or statute or are otherwise provided for payment; (7) Services not directly related to the plan of care; (8) Services specified in the plan of care when the plan of care has not been signed by the participant or the participant's legally authorized representative; (9) Services described in the plan of care whenever those services are no longer needed or appropriate because of a major change in the participant's condition or nursing care needs;

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Program	Limitations
(Continued) 4.B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	(10) Services which duplicate or supplant services rendered by the participant's family caregivers or primary caregivers as well as other insurance, other governmental programs, or Medicaid Program services that the participant receives or is eligible to receive; (11) Services provided for the convenience or preference of the participant or the primary caregiver rather than as required by the participant's medical condition; (12) Services provided by a nurse who does not possess a valid, current, signed, unrestricted nursing license to provide nursing services in the jurisdiction in which services are rendered; (13) Services provided by a nurse who does not have a current, signed cardiopulmonary resuscitation (CPR) certification for the period during which the services are rendered; (14) Nursing services rendered in a provider's home; (15) Respite services; and (16) Services provided by school health-related services that are not included on a child's IEP or IFSP. <u>Other Licensed Practitioners</u> A. The following practitioners are allowed: (1) Registered Nurse (RN), or; (2) Licensed Practical Nurse (LPN) B. These practitioners must provide services in accordance with §440.60 C. These practitioners provide supervision to unlicensed practitioners including a Certified Nursing Assistant (CNAs) who is also Certified Medical Technicians (CMTs), or; a Home Health Aid (HHA) who is also a CMT. Supervision of these practitioners must follow what is outlined in the State's Scope of Practice Act for RNs and LPNs COMAR 10.27.11.04. D. The supervising RN or LPN will assume professional responsibility for the services provided by the CNA/CMT and HHA/CMT according to the State's Criteria for Delegation COMAR 10.27.11.03

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Program | Limitations

Reserved For Future Use

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Program	Limitations
Services that require Preathorization (Continued)	6. Durable medical equipment covered only under EPSDT requires preauthorization as specified under 5. - 10., pages 32 E. - F., Attachment 3.1A of the State Plan. 7. Intermediate care facility - alcoholic (Type D) services when: A. The recipient is placed in an out-of-state facility. Adequate documentation shall be provided demonstrating that the placement meets one of the conditions as follows: (1) Effective services at an in-state facility are not available; (2) For similar services, an inpatient placement is not currently available in Maryland; or (3) The recipient resides out-of-state and the cost for the out-of-state service is comparable to the cost of similar services in Maryland. B. Services which are determined by Medicare to be ineffective, unsafe, or without proven clinical value are generally presumed to be not medically necessary, but will be preauthorized if the provider can satisfactorily document sufficient medical necessity. 8. All other necessary health care services covered under section 1905(a) of the Social Security Act.

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PROGRAM	LIMITATIONS
(Continued) 4. C. Family planning services & supplies for individuals of child bearing age	Services must be rendered as follows: 1. Services must be under the direction of a licensed physician. 2. All Family Planning Clinics must adhere to nationally recognized Family Planning standards. ~~3. Billing time limitations:~~ ~~a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.~~ ~~b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:~~ ~~(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and~~ ~~(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.~~ ~~c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.~~ ~~d. A claim which is rejected for payment due to improper completion or incomplete information of individuals under shall be paid only if it is properly completed, 21 years of age, and resubmitted, and received by the Program within treatment of conditions the original 6 month period, or within 60 days of rejection, whichever is later.~~ ~~e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.~~

See Page 9-2

06/07/2019
Hand written note, "See Page 9-2" references an inactive page.

For current language related to billing time limitations see Attachment 4.19A.

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Supersedes
TN No. _____

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Effective Date JAN 28 1991

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4. C. Family planning services and family planning related services for women and men of any age seeking contraceptive services.

Covered Services

A. The family planning program covers services and supplies to prevent or delay pregnancy and medical, diagnostic and treatment services provided pursuant to a family planning visit.
B. Family planning services and supplies are limited to those services and supplies whose primary purpose is family planning and are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90% matching rate. Family planning services are provided, as listed below:
    a. Approved methods of contraception;
    b. Contraceptive management, patient education, and counseling.
    c. Sexually transmitted infection (STI)/ sexually transmitted disease (STD) testing, pap smears, and pelvic exams in conjunction with the family planning method of choice;
    d. Drugs, supplies, or devices related to services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements.
C. Family planning related services and supplies are defined as those services provided as part of or as follow up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Family planning related services are provided, as listed below:
    a. Colposcopy and procedures done during a colposcopy or repeat pap smear performed as a follow up to an abnormal pap smear which is done as part of a routine/periodic family planning visit.
    b. Drugs for the treatment of STIs/STDs. A follow up visit for the treatment/drugs and subsequent follow up visits to rescreen for STIs/STDs may be covered.
    c. Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are diagnosed during a routine/periodic family planning visit. A follow up visit for the treatment/drugs may also be covered.
    d. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting.
    e. Treatment of major complications arising from a family planning procedure such as:
        i. Treatment of a perforated uterus due to an intrauterine device insertion;
        ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
        iii. Treatment of surgical or anesthesia related complications during a sterilization procedure.

Limitations:

1. Preconception/Infertility Services.
2. Drugs for the treatment of HIV/AIDS and hepatitis.
3. Transportation services.
4. Individuals who have had a sterilization procedure or a hysterectomy are not covered for the family planning services/supplies provided through this program.

Tobacco Cessation Counseling Services for Pregnant Women

4. D 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

X (i) By or under supervision of a physician;

X (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

___ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time)

*describe if there are any limits on who can provide these counseling services

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: [X] No limitations [ ] With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

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PROGRAM	LIMITATIONS
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.	A. The Physician Program covers medically necessary physician services when the services are provided by licensed physicians. When a service is provided as part of a health-related service in schools or in the child's home, it must be determined necessary and included as part of a child's IEP or IFSP. All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist. B. Physician Services which are not covered are: 1. Services not medically necessary; 2. Reserve for future use. 3. Nonemergency dialysis services related to chronic kidney disorders unless they are provided in a Medicare-certified facility; 4. Services which are investigational or experimental; 5. Autopsies; 6. Physician services included as part of the cost of an inpatient facility, hospital outpatient department, or free-standing clinic; 7. Payment to physicians for specimen collection, except by venipuncture and capillary or arterial puncture; 8. Reserve for future use.

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PROGRAM	LIMITATIONS
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.	9) Immunizations required for travel outside the continental United States. 10) Service which are provided outside of the United States; 11) Acupuncture; 12) Radial keratomy; 13) Sterilization reversals. 14) Injections, and visits solely for the administration of injections, unless medical necessity and the patient's inability to take appropriate oral medications are documented in the patient's medical records; 15) Visits solely to accomplish one of more of the following: a. Prescription, drug or food supplement pick-up, collection of specimens for laboratory procedures; b. Recording of an electrocardiogram; c. Ascertaining the patient's weight;

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PROGRAM	LIMITATIONS
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.	d. Interpretation of laboratory tests or panels which are considered to be part of the office visit and may not be billed separately; and 17. Drugs and supplies dispensed by the physician which are acquired by the physician at no cost. C. Preauthorization: The Program will preauthorize services when the provider submits adequate documentation demonstrating that the service is medically necessary. Authorizations for cross-over claims for dual-eligibles, which are normally required by the Program, are waived when the service is covered and approved by Medicare since the State's responsibility in this case is only to pay the co-payment for the service covered by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing the service. D. The following procedures or services require preauthorization by the Program: 1. Services rendered to an inpatient before one pre-operative inpatient day;

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PROGRAM	LIMITATIONS
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.	2. Cosmetic surgery - Preauthorization will determine whether there is medical documentation that the physical anomaly being addressed by the surgery represents a significant deviation from the normal state and affects the patient's health to a degree that it impairs his or her ability to function in society; 3. Consultations provided by physicians specializing in radiology or pathology; 4. Lipectomy and panniculectomy - Preauthorization will determine whether there is an abnormal amount of redundant skin and subcutaneous tissue which is causing significant health problems for the patient; 5. Transplantation of vital organs; 6. Surgical procedures for the treatment of morbid obesity; and 7. Elective services from a non-contiguous state.

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PROGRAM	LIMITATIONS
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.	E. Certain surgical procedures identified under "Inpatient Services" (Attachment 3.1A page 12B number 11) must be preauthorized when performed on a hospital inpatient basis unless: 1. The patient is already a hospital inpatient for a medically necessary condition unrelated to the surgical procedure requiring preauthorization, or 2. An unrelated procedure which requires hospitalization is being performed simultaneously.

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

Covered Services

A. The Podiatrist Program covers medically necessary podiatric services when the services are provided by a licensed and legally authorized podiatrist in the state in which the service is provided.
B. Routine podiatric care, which refers to the cutting or removing of corns and calluses, and the trimming, cutting, clipping, or debriding of toenails, is limited to one visit every 60 days for participants who have diabetes or peripheral vascular diseases that affect the lower extremities. This limit may be exceeded based on medical necessity.

Limitations

Under the Podiatry Program, the following services are not covered:

1. Physical therapy;
2. Orthotics and inlays of any type, and related services;
3. Disposable medical supplies;
4. Administration of anesthesia as a separate charge;
5. Drugs and supplies which are acquired by the podiatrist at no cost;
6. Personal hygiene care;
7. Routine care, except visits for participants who are diabetic or who have a vascular disease affecting the lower extremities;
8. Non-surgical hospital visits;
9. Laboratory or x-ray services not performed by the provider or under the direct supervision of the provider;
10. Podiatric inpatient hospital services rendered during an admission denied by the utilization control agent or during a period that is in excess of the length of stay authorized by the utilization agent;
11. More than one visit per day for the same service unless adequately documented in the patient's medical record as an emergency;
12. Visits by or to the podiatrist solely for the purpose of the following:
    a. Prescription or drug pick-up;
    b. Collection of specimens for laboratory procedures, except by venipuncture, capillary or arterial puncture; and
    c. Interpretation of laboratory tests or panels;
13. Services not identified by the Department as medically necessary or covered;
14. Injections and visits solely for the administration of injections;
15. Services rendered by mail, telephone, or otherwise not one-to-one, in person;
16. Completion of forms or reports;
17. Broken or missed appointments;
18. Investigational or experimental drugs or procedures; and
19. Services prohibited by the Maryland Podiatry Act or the State Board of Podiatric Medical Examiner.

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Program	Limitations
6. b. Optometrists Services	A. Eye examinations: A maximum of one every year for recipients younger than 21 years old, unless the time limitations are waived by the Department, based on medical necessity. B. The following are not covered: 1. Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients 21 years old and older; 2. Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients which were not ordered as a result of a full or partial EPSDT screen; 3. Repairs, except when repairs to eyeglasses are cost effective compared to the cost of replacing with new glasses. 4. Combination or metal frames except when required for proper fit;

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Program	Limitations
6. b. Optometrists Services (continued)	5. Cost of travel by the provider; 6. A general screening of a Medical Assistance population; 7. Visual training sessions which do not include orthoptic treatment; 8. Routine adjustment. C. See also limitations under 12D.
Services that require preauthorization	A. The following services require preauthorization: 1. All eye examinations that exceed Program limitations; 2. Specified eyeglasses and eyeglasses that exceed Program limitations; 3. Contact lenses; 4. Sub-normal vision aid examination and fitting; 5. Orthoptic treatment sessions; 6. Plastic lenses costing more than equivalent glass lenses unless there are six or more diopters of spherical correction or three or more diopters of astigmatic correction; 7. Absorbtive lenses, except cataract; 8. Opthalmic lenses or optical aids when the diopter correction is less than:

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Program	Limitations
Services that require preauthorization (continued)	a. -0.50D. sphere for myopia in the weakest meridian; b. +075D. sphere for hyperopia in the weakest meridian; c. +0.75 additional for presbyopia d. ± 0.75D. cylinder for astigmatism; e. A change in axis of 5° for cylinders of 1.00 diopter or more; f. A total of 4Δ (prism diopters) lateral or a total of 1Δ vertical. B. Preauthorization is issued when: 1. Program procedures are met: 2. Program limitations are met; 3. The provider submits to the Department adequate documentation demonstrating that the service to be preauthorized is medically necessary. C. Preauthorization is valid only for services rendered or initiated within 60 days of the date issued. D. Preauthorization normally required by the Program is waived when the service is covered and approved by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing. Non-Medicare claims require preauthorization according to §§A-C.

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PROGRAM	LIMITATIONS
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. c. Chiropractors' services	A. The Program covers medically necessary chiropractic manipulative treatment for children under age 21 years when the services are provided by appropriately qualified staff as described below. Services must be diagnostic, rehabilitative or therapeutic in addition to being directly related to the written treatment order. B. In order to participate under the ESPDT Program, a chiropractor: a. Must be licensed by the Maryland Board of Chiropractic Examiners; b. Must meet the federal standards established in 42 C.F.R 440.60(b); and c. Shall comply with the requirements in COMAR Title, Subtitle 43, et seq. C. The Program does not cover: 1. Chiropractic Services for adults ages 21 and over; 2. Services provided in a facility or by a group where reimbursement for chiropractic services are covered by another segment of the Program; 3. Experimental treatment.

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

d. Nutritionist

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

B. Nutrition services covered by Maryland Medicaid include:

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

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

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

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

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

Advanced Practice Nurse Services

This section includes certified nurse practitioners, certified nurse midwives and certified registered nurse anesthetists.

Covered Services

A. The Program covers medically necessary advanced practice nurse services rendered to participants as follows:

1. Certified nurse practitioner services provided within the provider's scope of practice as described in State Law and authorized in the state in which the services are rendered;
2. Certified nurse midwife services provided within the provider's scope of practice as described in State Law and authorized in the state in which the services are rendered;
3. Certified registered nurse anesthetist services provided within the provider's scope of practice and in collaboration with an authorized provider as described in State Law and authorized in the state in which the services are rendered;
4. Laboratory services when the advanced practice nurse provider is not registered as a medical laboratory; and
5. Drugs and supplies within the provider's scope of practice.

B. The rendered advanced practice nurse services shall be medically necessary as described in the participant's medical record in sufficient detail to support the request for payment.

Limitations

Under advanced practice nurse services, the Program does not cover the following:

1. Services not medically necessary;
2. Services prohibited by the Maryland Nurse Practice Act or by the Maryland State Board of Nursing;
3. Advanced practice nursing services included as part of the cost of:
    a. An inpatient facility;
    b. A hospital outpatient department; or
    c. A freestanding clinic;
4. Visits by or to the provider solely for the purpose of the following:
    a. Prescription, drug, or food supplement pick-up;
    b. Recording of an electrocardiogram;
    c. Ascertaining the patient's weight;
    d. Interpretation of laboratory tests or panels; or
    e. Prescribing or administering medications;
5. Drugs and supplies which are acquired at no cost;

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

6e. Advanced Practice Nurse Services

6. Injections and visits solely for the administration of injections, unless medical necessity and the participant's inability to take oral medications are documented in the participant's medical record;
7. Services paid under the free-standing dialysis program as described in State Law;
8. Immunizations required for travel outside the United States;
9. Prescriptions and injections for central nervous system stimulants and anorectic agents when used for weight control;
10. Acupuncture;
11. Hypnosis;
12. Travel expenses;
13. Investigational or experimental drugs and procedures;
14. Specimen collection, except by venipuncture and capillary or arterial puncture, as a separate service;
15. Laboratory or X-ray services performed by another facility, which shall be billed to the Program directly by the facility; and
16. For certified nurse midwives, a separate visit charge on date of delivery.

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

d. Other practitioners' services: Pharmacists services

Covered Services

A. Pharmacists are able to furnish services within the lawful scope of their practice as defined by State Law and when the services are covered by Maryland Medicaid.

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

6. g. Licensed Mental Health Practitioners:

- Licensed Registered Nurse Practitioner with a specialty in Psychiatry
- Licensed Advanced Practice Registered Nurse certified in Psychiatric Mental Health
- Licensed Clinical Professional Counselor
- Licensed Psychologist
- Licensed Clinical Social Worker
- Licensed Clinical Professional Art Therapist

A. Preauthorization:

Providers must obtain preauthorization for all services for which a claim is to be submitted with the exception of IEP/IFSP services where the authorization for the service is contained within the IEP/IFSP.

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6. Medical care and any other type of remedial care recognized under State law, furnished by a licensed practitioners within the scope of their practice as defined by State law.
   h. Physician Assistant Services

Physician Assistant Services

The Program reimburses physician assistants directly for medically necessary services rendered to recipients in accordance with the functions allowed under COMAR 10.09.55 and the delegation agreement with a licensed physician. If out of State, the Program reimburses only in accordance with the scope of practice allowed by the licensing authority in the state in which services are provided. These services shall be clearly related to the recipient's medical needs and described in the recipient's medical record in sufficient detail to support the invoice submitted for those services.

Physician assistants may practice in Maryland only if:

1) They are licensed to practice as a physician assistant in Maryland;
2) They are in compliance with COMAR 10.32.03;
3) They have a delegation agreement with a supervising physician that outlines the physician assistant's duties with the medical practice or facility which has been filed with and approved by the Board of Physicians; and
4) They have a delegation agreement to perform advanced duties with a supervising physician that documents any specialized training, education and experience of the physician assistant.

Limitations:

Services which are not covered are:

1. Services not encompassed by the delegation agreement with a supervising physician that outlines the physician assistant's duties with the medical practice or facility which has been filed with and approved by the Board of Physicians;
2. Services not medically necessary;
3. Services prohibited by COMAR 10.09.55;
4. Services prohibited in the state in which services are provided;
5. Physician Assistant services included as part of the cost of an inpatient facility, hospital outpatient department, or free-standing clinic;
6. Visits solely to accomplish one or more of the following:
   a. Prescription, drug or food supplement pick-up, collection of specimens for laboratory procedures;
   b. Recording of an electrocardiogram;
   c. Ascertaining the patient's weight; and
   d. Interpretation of laboratory tests or panels which are considered to be part of the office visit and may not be billed separately;
7. Drugs and supplies dispensed by the physician assistant which are acquired at no cost;

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

i. Licensed Behavior Analyst Services

A. The Medicaid Program shall provide coverage for, and payment to, Licensed Behavior Analysts for services provided within their scope of practice. Consistent with state law and acting within their scope of practice, Licensed Behavior Analysts will provide supervision to Assistant Behavior Analysts, Registered Behavior Technicians and Behavior Technicians and assume professional responsibility for the services rendered by an unlicensed provider under their supervision. All licensed and unlicensed providers must meet the requirements established by the Department of Health and Mental Hygiene.

B. Provider Qualifications

1. Licensed Behavior Analysts shall:
    a. Be licensed by the Maryland Board of Professional Counselors and Therapists;
    b. Have a current certification of Board Certified Behavior Analyst-Doctoral (BCBA-D) or Board Certified Behavior Analyst (BCBA) by the Behavior Analyst Certification Board (BACB);
    c. Have no active sanctions or disciplinary actions imposed by the jurisdictional licensing or certification authority, Medicare Program, Maryland Medical Assistance Program, or other federally funded healthcare program; and
    d. Have a completed criminal background check according to the State's requirements.

2. Assistant Behavior Analysts shall:
    a. Have a current certification of Board Certified Assistant Behavior Analysts (BCaBAs) by the BACB;
    b. Have no active sanctions or disciplinary actions imposed by the jurisdictional licensing or certification authority, Medicare Program, Maryland Medical Assistance Program, or other federally funded healthcare program;
    c. Have a completed criminal background check according to the State's requirements;
    d. Work under the direct supervision of a licensed psychologist, a licensed BCBA-D or a licensed BCBA; and
    e. Have the supervisory relationship documented in writing.

3. Registered Behavior Technicians (RBTs) and Behavior Technicians (BTs) shall:
    a. Be 18 years old or older;
    b. Be currently registered by the BACB or become registered by the BACB not later than December 31, 2018;
    c. Have a high school diploma or national equivalent;
    d. Have a completed criminal background check according to the State's requirements;
    e. Work under the direct supervision of a licensed psychologist, a licensed BCBA-D or a licensed BCBA; and
    f. Have the supervisory relationship documented in writing.

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PROGRAM	LIMITATIONS
7. Home Health Services – General Skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech pathology services, and medical supplies.	The state will comply with the Electronic Visit Verification System (EVV) requirements for home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act. 1. Providers of home health services must: a. Be licensed as a home health agency in the state; and b. Participate under Medicare as a home health agency. 2. Services must be: a. Provided upon the written order of the physician, nurse practitioner, physician assistant, or clinical nurse specialist with prescriptive authority in accordance with State law, and furnished under the current plan of treatment; b. Consistent with the current diagnosis and treatment of the participant's condition; c. In accordance with accepted standards of medical practice; d. Required by the medical condition rather than the convenience or preference of the participant; e. Considered under accepted standards of medical practice to be a specific and effective treatment for the participant's condition; f. Required on a part-time, intermittent basis when skilled nursing services are rendered; g. Rendered by an approved provider in the participant's home, or other setting when normal life activities take the participant outside the home; h. Adequately described in the signed and dated progress notes; i. Documented as received by the participant as indicated by the participant’s signature or signature of a witness; j. Documented that a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who is not employed by the home health agency, has had a face-to-face encounter with the participant no more than 90 days before the home health start of care date or within 30 days after the start of the home health care, including the date of the encounter; and k. Documented by the attending acute or post-acute physician, the clinical findings of the face-to-face encounter for participants admitted immediately to home health upon discharge from a hospital or post-acute setting.

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PROGRAM	LIMITATIONS
7. Home Health Services-General Skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech pathology services, and medical supplies.	3. Home health aide services must come under the direct supervision of a nurse. The home health agency must have a registered nurse provide biweekly supervisory visits to the recipient's home. Every second visit shall include observations of the delivery of services by the aide to the recipient.

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PROGRAM	LIMITATIONS
7. Home Health Services—General Intermittent skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech pathology services, medical supplies, and newborn early discharge assessment visits.	The following services require preauthorization: 1. More than one visit per type of service per day. 2. Any service or combination of services rendered during any 30-day period for which the provider anticipates payments from the program in excess of the Medicaid average nursing facility rate. 3. Four or more hours of care per day whether the 4-hour limit is reached in one visit or in several visits in one day. 4. Any instances in which home health aide services without skilled nursing services are provided.

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PROGRAM	LIMITATIONS
7. Home Health Services—General Intermittent skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech pathology services, medical supplies, and newborn early discharge assessment visits.	The following services are not covered under the program: 1. Non-skilled nursing and therapy services. 2. Services that are not medically necessary. 3. Initial assessments by any therapist or a registered nurse. 4. Services provided for the convenience or preference of the recipient or primary caregiver rather than as required by the recipient's medical condition. 5. Services which duplicate or supplant services performed by the recipient and those services rendered by the recipient's family. 6. Services which are covered by other insurance or entitlement programs. 7. Services primarily for the purpose of housekeeping. 8. Services rendered to recipients with chronic conditions when those recipients require only personal care services. 9. Meals. 10. The newborn early discharge assessment visit is limited to one visit per recipient and may not be provided on the same day as another skilled nursing visit billed under this program.

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7. Home Health Services - **Medical Supplies and Equipment**

Medical supplies are healthcare related items that are consumable or disposable, or cannot withstand repeated use by more than one participant, that are required to address a participant's medical disability, illness or injury.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to a participant in the absence of a disability, illness, or injury, can withstand repeated use, and can be reusable or removable.

Medical supplies and equipment and appliances are covered when:
1. Ordered by a physician or a licensed practitioner of the healing arts acting within the scope of practice authorized under State law, as part of a written plan of care reviewed by the ordering practitioner annually.
2. Medically necessary; and
3. Furnished by enrolled Maryland Medicaid medical equipment and supply providers.

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7. a. Home Health Services – Hearing Aids

The Home Health Services benefit covers medically necessary hearing aids when the services are provided by appropriately licensed providers as directed below.

A. Medically necessary hearing aids include:
   1) Unilateral or bilateral hearing aids that are:
      a. Not used or rebuilt;
      b. Meet the current standards set forth in 21 CFR §§801.420 and 801.421;
      c. Recommended and fitted by an audiologist when in conjunction with written medical clearance from a physician who has performed a medical examination within six months;
      d. Sold on a 30-day trial basis; and
      e. Fully covered by a manufacturer's warranty for a minimum of two years.
   2) Hearing aid accessories, as listed below:
      a. Ear molds
      b. Batteries; and
      c. Other hearing aids accessories as determined to be medically necessary.

B. Audiologists shall be licensed by the Maryland Board of Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists to practice audiology, as defined in Health Occupations Article, Title 2, Annotated Code of Maryland, or by the appropriate licensing body in the jurisdiction where the audiology services are performed.

C. The Maryland Medicaid Home Health Services Benefit covers the following hearing aids limited to:
   1) The initial coverage of:
      a. Bilateral hearing aids for children younger than 21 years of age;
      b. Unilateral hearing aids for participants age 21 years old and older unless otherwise approved by the Department or its designee;
   2) Replacement of unilateral or bilateral hearing aids once every five years unless the Program approves more frequent replacement;
   3) Replacement of unilateral hearing aid once every five years for participants over 21 years of age
   4) A maximum of 76 disposable batteries per participant per 12-month period for a unilateral hearing aid or 152 batteries per participant per 12-month period for bilateral hearing aids purchased from the Department not more frequently than every six months, and in quantities of 38 or fewer for unilateral hearing aid, or 76 or fewer for a bilateral hearing aid;
   5) Charges for routine follow-ups and adjustments which occur more than 60 days after the dispensing of a new hearing aid;
   6) A maximum of two unilateral earmolds or four bilateral earmolds per 12- month period for participants under 21 years of age;
   7) A maximum of one unilateral earmold or two bilateral earmolds per 12- month period for participants over 21 years of age;
   8) Replacement of hearing aids and equipment, if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition;
   9) Spare or backup hearing aids;

10) Repairs to spare or backup hearing aids, equipment or supplies;
11) Investigational or experimental services or devices;
12) Replacement of improperly fitted earmold(s) unless the:
    a. Replacement service is administered by someone other than the original provider; and
    b. Replacement service has not been claimed before;
13) Additional professional fees and overhead charges for a new hearing aid when a dispensing fee claim has been made to the Program; and
14) Loaner hearing aids.

D. The following audiology services require preauthorization:
    1) All hearing aids;
    2) Certain hearing aid accessories;
    3) Repairs for hearing aids exceeding $500.

E. Preauthorization is valid:
    1) For services rendered or initiated six months from the date the preauthorization was issued; and
    2) If the patient is an eligible participant at the time the service is rendered.

F. The following written documentation shall be submitted by the provider to the Department or its Designee with each request or preauthorization of hearing aids:
    1) Audiology report documenting medical necessity of the hearing aids,;
    2) Interpretation of the audiogram; and
    3) For initial hearing amplification device requests only, a medical evaluation by a physician supporting the medical necessity of the hearing aids within six months of the preauthorization request.

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Program	Limitations
8. Private Duty Nursing	A. Private Duty Nursing Services are nursing services provided to qualified individuals who are under age 21. Services are provided in a participant's own home or another setting when normal life activities take the participant outside his or her home except for limitations described in Section D below. B. Covered services include: (1) An initial assessment of a recipient's medical need for private duty nursing by a licensed registered nurse; and (2) On-going private duty nursing services. To be a covered service, direct care nursing must be: (1) Ordered by the participant's primary medical provider (Orders must be renewed every 60 days); (2) Provided in accordance with a Plan of Care; (3) Provided by a registered or licensed practical nurse with a valid unrestricted license and a current certification in CPR; (4) Of a complexity, or the condition of the participant must require, that the judgment, knowledge, and skills of a licensed nurse are required and the service can not be delegated pursuant to Maryland's Nurse Practice Act (Health Occupations Article, Title 8, Annotated Code of Maryland; and (5) Of a scope that is more individual and continuous than nursing available under the Home Health Program.

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Program	Limitations
8. Private Duty Nursing	C. On-going private duty nursing services, with the exception of those services that are preauthorized through the IEP/IFSP process, must be preauthorized by the Medicaid Program. D. Private Duty Nursing services does not include: (1) Part time/ intermittent nursing services covered as Home Health Services; (2) Nursing services rendered by a nurse who is a member of the participant's immediate family or who ordinarily resides with the participant; (3) Custodial service; (4) Services not deemed medically necessary at the time of the initial assessment or plan of care review; (5) Services delivered by a licensed nurse who is not directly supervised by a licensed registered nurse who documents all supervisory visits and activities; (6) Services provided to a participant in a hospital, residential treatment center, intermediate care facility for mental retardation or addiction, or a residence or facility where private duty nursing services are included in the living arrangement by regulation or statute or are otherwise provided for payment; (7) Services not directly related to the plan of care; (8) Services specified in the plan of care when the plan of care has not been signed by the participant or the participant's legally authorized representative; (9) Services described in the plan of care whenever those services are no longer needed or appropriate because of a major change in the participant's condition or nursing care needs;

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Program	Limitations
8. Private Duty Nursing	(10) Services which duplicate or supplant services rendered by the participant's family caregivers or primary caregivers as well as other insurance, other governmental programs, or Medicaid Program services that the participant receives or is eligible to receive; (11) Services provided for the convenience or preference of the participant or the primary caregiver rather than as required by the participant's medical condition; (12) Services provided by a nurse who does not possess a valid, current, signed, unrestricted nursing license to provide nursing services in the jurisdiction in which services are rendered; (13) Services provided by a nurse who does not have a current, signed cardiopulmonary resuscitation (CPR) certification for the period during which the services are rendered; (14) Direct payment for supervisory nursing visits; (15) Nursing services rendered by a nurse in the nurse's home; (16) Nursing services not documented as received by the participant as indicated by the lack of the participant's signature, or the signature of a witness, on the nursing provider's official form; (17) Respite services; and (18) Services provided by school health-related service providers that are not included on a child's IEP or IFSP.

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9.a. Description of Services: CLINIC SERVICES
As defined in CFR §440.90

Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(a) Services furnished at the clinic by or under the direction of a physician or dentist.

(b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address

Provider Types:

- **Local Health Departments** – a division of a local government responsible for the oversight and medical care relating to public health.

- **General Clinics** – general medical practice run by one or more general practitioners and/or internal medicine providers.

- **Family Planning Clinics** – a clinic that provides reproductive health services.

- **Outpatient Mental Health Centers** – a clinic that provides specialty mental health services.

- **Free-Standing Dialysis Facility Services** – a facility that provides dialysis services. Covered services include:

    1. Hemodialysis;
    2. Peritoneal dialysis;
    3. Continuous ambulatory peritoneal dialysis;
    4. Continuous cycling peritoneal dialysis;
    5. Home dialysis training;
    6. Laboratory services; and
    7. Drugs and supplies.

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Limitations:

Include:

- Any services identified by the Department as not medically necessary or not covered;
- Investigational and experimental drugs and procedures;
- Drugs and supplies which are acquired at no cost;
- Laboratory or X-ray services performed by another facility, which shall be billed to the Program directly by the facility;
- Visits solely for the purpose of one or more of the following
    - Prescription, drug or supply pick;
    - Collection of laboratory specimens, except by venipuncture and capillary or arterial puncture, as a separate service;
    - Ascertaining the patient's weight; and
    - Measurement of blood pressure
- Injections and visits solely for the administration of injections, , unless medical necessity and the participant's inability to take oral medications are documented in the participant's medical record;
- Immunizations required for travel outside the Continental U.S.;
- Visits solely for group or individual health education;
- Separate billing for services which are included as part of another service;
- Separate reimbursements to a physician for services provided in a clinic in addition to the clinic reimbursement;
- Services not approved by a licensed physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law;
- Services beyond the provider's scope of practice;
- Services rendered but not appropriately documented;
- Services rendered by mail, telephone, or otherwise not one-to-one, in person, with the exception of approved telemedicine services;
- Completion of forms or reports;
- Broken or missed appointments; and
- Travel to and from site of service.

Reserve for Future Use

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PROGRAM

9. Clinic Services
c. Ambulatory Surgery

LIMITATIONS

A. The Ambulatory Surgery program covers medically necessary facility services rendered to recipients in a free-standing Medicare-certified ambulatory including:
   (1) Diagnostic, curative, palliative, or rehabilitative services, when clearly related to the recipient's individual needs;
   (2) Surgical procedures which meet the standards described in 42 CFR, Subpart D, §416.65, and as published by the Centers for Medicare and Medicaid Services; and
   (3) Dental services performed by a dentist.

B. Ambulatory Surgery providers shall meet requirements listed in COMAR 10.09.36.03, "Conditions for Participation in the Medicaid Program".

   Specific requirements for participation in the Program as a free-standing Medicare-certified ambulatory surgical center include all of the following:

   (1) Be approved by Medicare to furnish ambulatory surgical services to patients and maintain documentation of certification by the Department of Health and Human Services and the Centers for Medicare and Medicaid Services;
   (2) Have clearly defined, written, patient care policies;
   (3) Maintain adequate documentation of each recipient visit as part of the plan of care, which at a minimum, shall include:
      a. Date of service;
      b. Recipient's reason for visit;
      c. A brief description of service provided; and
      d. A legible signature and printed or typed name of the professional providing care, with the appropriate title;

   (4) Have written, effective procedures for infection control which are

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PROGRAM

9. Clinic Services
c. Ambulatory Surgery

LIMITATIONS

known to all levels of staff as specified in COMAR 10.06.01, which provides regulations for cooperative communicable disease and related conditions controlled by the Department, local health officers, medical laboratory directors, physicians, and other Maryland governmental agencies, as guided by policy statements from the Centers for Disease Control and Prevention and various other governmental agencies;

(5) Be approved by the state in which the service is provided, except where a Certificate of Need is not required;
(6) Provide for in-house Program evaluation and clinical record review which assess use of services for appropriateness in meeting a recipient's needs;
(7) Refer laboratory testing only to independent medical laboratory providers.

C. Limitations

The Maryland Medicaid Ambulatory Surgery program does not cover the following services in a free-standing Medicare certified ambulatory surgical center:

(1) Services not specified in COMAR 10.09.42.04, the "Covered Services" section of the Medicaid regulations for ASCs);
(2) Services not medically necessary;
(3) Investigational and experimental drugs and procedures;
(4) Services denied by Medicare as not medically necessary;
(5) Separate billing of services which are included in the composite Medicare rate for an ambulatory surgical center; and
(6) Surgical procedures which:
   a. Generally result in extensive blood loss;
   b. Require major or prolonged invasion of body cavities;

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PROGRAM	LIMITATIONS
9. Clinic Services c. Ambulatory Surgery	c. Directly involve major blood vessels; or d. Are generally emergency or life-threatening in nature; e. Commonly require system thrombolytic therapy; f. Are designed as requiring inpatient care (overnight); g. Can only be reported using a CPT unlisted surgical procedure code; or h. Are otherwise excluded under 42 CFR § 411.15; (7) Physician's services (including surgical procedures and all preoperative and postoperative services performed by a physician); (8) Anesthesia services; (9) Radiology services other than those integral to performance of a covered surgical procedure; (10) Diagnostic procedures other than those directly related to a covered surgical procedure; (11) Ambulance services; (12) Leg, arm, back and neck braces other than those that serve the function of a cast or splint; (13) Artificial Limbs; or (14) Non-implantable prosthetic devices and DME.

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Free-standing Urgent Care Centers

A. The Program covers medically necessary services rendered to recipients in a Free-standing urgent care center, defined as diagnostic, curative, palliative, or rehabilitative services, when clearly related to the recipient's individual needs; and includes:

(1) Treatment for acute illnesses with a sudden onset;
(2) Minor trauma;
(3) Physician services when rendered in accordance with Maryland regulations

B. Specific requirements for participation in the Program as a free-standing urgent care center include the following:

(1) Have clearly defined, written, patient care policies;
(2) Define the center's hours of operation and clearly communicate those hours of operation to the public and other relevant organizations;
(3) Ensure that patients seeking urgent care are seen without prior appointments;
(4) During the hours of operation, have at least one qualified physician present;
(5) Maintain adequate documentation of each recipient visit as part of the plan of care which at a minimum, shall include:
a) Date of service;
b) A description of the service provided; and
c) A legible signature and printed or typed name of the professional providing care, with the appropriate title;
(6) Have written, effective procedures for infection control which are known to all levels of staff; and
(7) Have laboratory testing and radiology services available to meet the needs of the patients receiving urgent care.

C. Limitations
The following services are not covered:

(1) Any service or treatment identified by the Department that is not medically necessary;
(2) Experimental or investigational services;
(3) Services which do not involve direct patient contact (face-to-face);
(4) Laboratory or x-ray services performed by another facility;
(5) Immunizations required for travel outside the Continental U.S.;
(6) Well child visits;
(7) Sports physicals; and
(8) Professional fees provided by physicians billed separately from the facility's charges.

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10. Dental Services

A. The Program provides a comprehensive package of medically necessary dental services for individuals younger than 21 years old, including but not limited to the following:
(1) Emergency, preventive, diagnostic, and treatment services;
(2) Semiannual cleaning, fluoride treatment and examination;
(3) Pit and fissure sealants for the occlusal surfaces of posterior permanent teeth that are without decay;
(4) Orthodontic care
(5) Consultations for individuals receiving services described in A(1), (2), (3) and (4) above;
(6) Drugs dispensed or injectable drugs administered by the dentist who meets the requirements of the Program;
(7) Oral Health assessment;
(8) General anesthesia during dental procedures when it is medically necessary;
(9) Fluoride varnish; and
(10) A complete radiographic survey or full series of X-rays of the mouth once every 3 years.

Under EPSDT, service limitations may be exceeded based on medical necessity.

B. The Program covers certain medically necessary dental services for adults 21 and older:
(1) Preventive;
(2) Restorative;
(3) Diagnostic;
(4) Endodontics;
(5) Periodontics;
(6) Oral surgery;
(7) Prosthodontics; and
(8) Emergency services.

C. The Program will reimburse for covered services in A and B above under the following conditions:
(1) The services are rendered in the dentist's office, the participant's home, a general acute hospital, a skilled or intermediate care nursing facility, a free-standing clinic, an EPSDT provider's office, an approved mobile dental unit or an Ambulatory Surgical Center (ASC); and
(2) The services are provided by or under the supervision of a dentist.

D. The Program places the following limitations on covered services:
(1) For any traumatic injury case, a provider may be reimbursed for a maximum of four panoramic or other extra-oral radiographs. When services are rendered by members of a group practice or association, reimbursement to the group practice or association shall also be limited to a maximum of four panoramic or other extra- oral radiographs

(2) Reimbursement for crowns will be limited to permanent resin fused to metal crowns, permanent porcelain fused to metal crowns, permanent nonprecious metal (full cast), provisional resin crowns, and stainless steel crowns.

(3) Composite restorations will be covered for all teeth when necessary for the particular conditions of the patient.

(4) The Program does not cover:

(a) Resin crowns without a metal superstructure;
(b) Porcelain crowns without a metal superstructure;
(c) Fixed bridge work;
(d) Cosmetic procedures;
(e) Inpatient hospital dental or oral health care services rendered during an admission;
(f) Drugs and supplies dispensed by the dentist which are acquired by the dentist at no cost;
(g) Referrals;
(h) Gold restorations, gold crowns, and gold replacement appliances;
(i) Services rendered without the required preauthorization;
(j) Services which are investigational or experimental; and
(k) For adults, implants, traditional comprehensive orthodontic treatment, and self-ligating braces.

E. Dental services may require preauthorization and are approved when medically necessary.

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PROGRAM
10. Dental Services

LIMITATIONS

(2) The services are provided by or under the supervision of a dentist or by or under the supervision of a certified EPSDT primary care provider for the purpose of applying fluoride varnish.

D. The Program limitations are included in Maryland Medicaid regulations: COMAR 10.09.05.05.

(1) Reimbursement for a complete radiographic survey or full series of X-rays of the mouth may not be made more frequently than once every 3 years to the same provider, or in the case of a group practice, to any partner or associate of that practice, unless medically necessary or specifically required or requested by the Program.

(2) For any traumatic injury case, a provider may be reimbursed for a maximum of four panoramic or other extra-oral radiographs. When services are rendered by members of a group practice or association, reimbursement to the group practice or association shall also be limited to a maximum of four panoramic or other extra-oral radiographs.

(3) Endodontic therapies and pulpectomies may not be covered when:

(a) Root resorption has started and exfoliation is imminent;

(b) Gross periapical or periodontal pathosis is demonstrated on the radiograph; or

(c) The general oral condition does not justify endodontic therapy.

(4) Reimbursement for crowns will be limited to permanent resin fused to metal crowns, permanent porcelain fused to metal crowns, permanent nonprecious

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metal (full cast), provisional resin crowns, and stainless steel crowns.
(5) Composite restorations will be covered for all teeth when necessary for the particular conditions of the patient.
(6) Replacement dentures for recipients who meet the requirements of Regulation .04A(3) of this chapter will be covered only when:
(a) Dentures have been lost, broken, or stolen after 1 year of placement; or
(b) Adjustment, repair, relining, or rebasing of the patient's present denture does not make it serviceable.
(7) Rebasing is included in the 6 months of aftercare following denture placement, and may not be provided more frequently than once every 2 years after that.
(8) Reimbursement for endodontic therapy includes all diagnostic tests, preoperative and postoperative radiographs, preoperative and postoperative treatments, pulpotomies and pulpectomies.
(9) Reimbursement for a sinus closure will only be made when this service is rendered as a separate procedure and not in conjunction with the removal of a tooth.
(10) Separate reimbursement will not be made for cavity liners and office visits, as these procedures are considered to be components of the necessary treatment. These services may not be billed to the recipient.
(11) The provider may bill for emergency treatment or for the actual dental procedure rendered during an emergency visit, but not for both.
(12) Gold restorations, gold crowns, and gold replacement appliances are not covered services.
(13) The Program's fee for a complete series of intra-oral radiographs including

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bitewings, represents the maximum payable for any combination of periapical X-rays and bitewings.
(14) Assistant surgeons' services are covered only:
(a) As specified in Regulation .07M of this chapter;
(b) If the procedures were rendered in a hospital or a Medicare-certified ambulatory surgery center; and
(c) If the assistant surgeon is a dentist.

The Program does not cover:
(1) Resin crowns without a metal superstructure;
(2) Porcelain crowns without a metal superstructure;
(3) Fixed bridge work;
(4) Cosmetic procedures;
(5) Inpatient hospital dental or oral health care services rendered during an admission denied by the utilization control agent or during any period that is in excess of the length of stay authorized by the utilization control agent;
(6) Services which are investigational or experimental;
(7) Local anesthesia as a separate charge;
(8) Duplication of dentures;
(9) Drugs and supplies dispensed by the dentist which are acquired by the dentist at no cost;
(10) Referrals;
(11) Diagnostic models as a separate charge;
(12) Office visits as a separate service;
(13) Immediate dentures;
(14) Consultant payments when a member of the nurse staff of a hospital either requests or provides the consultations or, in the case of a group practice, to any partner

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or associate of that practice who either requests or provides the consultation;
(15) Aftercare services as a separate charge to a provider or, in the case of a group practice, to any partner or associate of that practice;
(16) Services when reimbursement is included under another segment of the Program; and
(17) Unilateral partial dentures replacing less than three teeth, excluding third molars.

E. Certain dental services require preauthorization. Preauthorization requirements can be found in Maryland Medicaid regulations: COMAR 10.09.05.06.

F. Preauthorization normally required by the Program is waived when the services are covered and approved by Medicare.

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PROGRAM	LIMITATIONS
11. Physical therapy and related services a. Physical Therapy	A. The Physical Therapy Program covers medically necessary physical therapy services prescribed in writing by a physician, dentist, or podiatrist when the services are provided by appropriately qualified staff as described below. Services must be diagnostic, rehabilitative or therapeutic in addition to being directly related to the written treatment order. B. Physical therapy services and physical therapists shall meet requirements listed in 42 CFR 440.110. In addition, a physical therapist shall be licensed by the State Board of Physical Therapy Examiners of Maryland to practice physical therapy, as defined in Health Occupations Article, Title 13, Annotated Code of Maryland, or by the appropriate licensing body in the jurisdiction where the physical therapy services are performed. C. Licensed physical therapists meeting the qualifications in B may supervise licensed physical therapy assistants. The physical therapy assistants may not enroll as Maryland Medicaid providers, however they may perform limited physical therapy under the supervision of the licensed physical therapist. Physical therapy assistants cannot for example, interpret measurements or develop treatment plans. These activities must be performed by the licensed physical therapists. D. The Physical Therapy Services Program does not cover: 1. Services provided in a facility or by a group where reimbursement for physical therapy is covered by another segment of the Program; 2. Services performed by physical therapy assistants when not under the direct supervision of a physical

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PROGRAM	LIMITATIONS
11. Physical therapy and related services a. Physical Therapy	therapist; 3. Services performed by physical therapy aides; 4. Services provided by a school health-related service provider that are not included on a child's IEP or IFSP; or 5. Experimental treatment.

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PROGRAM	LIMITATIONS
11. Physical therapy and related services b. Occupational Therapy	A. The Occupational Therapy Program covers medically necessary occupational therapy when the services are provided by appropriately qualified staff as described below. Services must be diagnostic, rehabilitative, or therapeutic, in addition to being directly related to a written treatment plan. B. Occupational therapy services covered by Maryland Medicaid include: (1) Evaluation and Development of Treatment Plan- Occupational therapists are responsible for evaluating and developing a treatment plan that outlines the selected approaches and types of intervention to be used to enable the client to reach identified targeted outcomes. The plan must include activities that develop, improve, sustain, or restore skills in activities of daily living, work or productive activities, or leisure activities. The plan should also include strategies to educate client, family, caregivers, or others in carrying out appropriate non-skilled interventions. (2) Treatment – Treatment services will be provided in blocks of 15 minute increments, to enable people to do day-to-day activities despite impairments and activity limitations. This includes working on fine motor skills, addressing hand-eye coordination, teaching clients basic tasks related to activities of daily living, and teaching patients how to use specialized equipment.

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PROGRAM	LIMITATIONS
11. Physical therapy and related services b. Occupational Therapy	(3) Periodic Re-evaluation - Data will be collected and interpreted, after treatment to determine: a. A patient's response to treatment; b. Changes in the patient's status; c. The need for changes in the treatment plan; and d. Plans for discharge. C. Occupational therapy services and occupational therapists shall meet requirements listed in 42 CFR 440.110. In addition, an occupational therapist shall be licensed by the Maryland Board of Occupational Therapy to practice occupational therapy, as defined in Health Occupations Article, Title 10, Annotated Code of Maryland, or by the appropriate licensing body in the jurisdiction where the occupational therapy services are performed. D. Licensed occupational therapists meeting the qualifications in B may supervise licensed occupational therapy assistants. The occupational therapy assistants may not enroll as Maryland Medicaid providers however, they may perform limited occupational therapy under the direction of the licensed occupational therapist. Occupational therapy assistants cannot for example, conduct evaluations or develop initial treatment plans. These activities must be performed by the licensed occupational therapists. E. The Maryland Medicaid Occupational Therapy Services Program does not cover: (1) Services for adults ages 21 and over; (2) Services provided in a facility or by a group where reimbursement for occupational therapy is covered by another segment of the Program;

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PROGRAM	LIMITATIONS
11. Physical therapy and related services b. Occupational Therapy	(3) Services performed by occupational therapy assistants when not under the periodic supervision of an occupational therapist; (4) Services performed by occupational therapy aides; (5) Services provided by school health-related services providers that are not included on a child's IEP or IFSP; or (6) Experimental treatment.

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11. Physical therapy and related services:

c. Services for individuals with speech, hearing and language disorders (provided by or under the direction of a speech pathologist or audiologist)

1. Audiology Services:

A. The Audiology Program covers medically necessary audiology services when the services are provided by appropriately licensed providers as directed below.

B. Medically necessary audiology and hearing amplification services covered by Maryland Medicaid include:
   1) Audiology assessments using procedures appropriate for the participant's age and abilities;
   2) Hearing aid evaluations and routine follow-up for participants with identified hearing impairment and who currently use or are being considered for hearing aids;

C. Audiologists shall be licensed by the Maryland Board of Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists to practice audiology, as defined in Health Occupations Article, Title 2, Annotated Code of Maryland, or by the appropriate licensing body in the jurisdiction where the audiology services are performed.

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RESERVE FOR FUTURE USE

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12. A. Prescribed Drugs

A. The following are not covered:

1. Non-legend drugs other than; insulin, Schedule V cough preparations, family planning products, enteric coated aspirin used in the treatment of arthritic conditions and any other cost effective medications as specified by the Program.
2. Any original prescription:
    a) For a controlled substance dispensed more than 30 days after the prescribing date; and
    b) For a non-controlled substance dispensed more than 120 days after the prescribing date.
3. Drugs supplied to hospital inpatients.
4. Experimental or investigational drugs.
5. Oral drugs or injections for central nervous system stimulants and anorectic agents when used for weight control.
6. Drug products for which Federal Financial Participation is prohibited pursuant to 42 CFR 441.25.
7. Ovulation stimulants for oral or parenteral administration.
8. Any Part D drug for individuals who are eligible for Medicare Part D benefits.
9. Drug products marketed by a manufacturer or distributor who has not entered into a rebate agreement with the Secretary of the Department of Health and Human Services as described in Section 1903 of the Social Security Act or a manufacturer who has not signed a rebate agreement with the State of Maryland prior to April 1, 1991, except Coverage will be allowed for single source drugs and innovator multiple source drugs if:
    a) The State has made a determination that the drug is essential to the health of the beneficiaries;
    b) The drug has been rated as 1-A by the Food Drug Administration (FDA); and
    c) The authorized prescriber has obtained approval for use of the drug in accordance with the States' prior authorization program as described in D of this Section (Preauthorization Requirements) of the Secretary has reviewed and approved the State's determinations.
10. No covered drug shall be reimbursed if:
    a) Federal financial participation from the Centers for Medicare and Medicaid Services is not available for the drug; or
    b) Prior authorization was required for the drug, but was not obtained.

A. Following are covered:

Smoking Cessation Products-The Medicaid agency will provide coverage of prescription and over-the counter (OTC) smoking/tobacco cessation covered outpatient drugs for patients covered under the Maryland Medical Assistance Program.

State: Maryland

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

12. A. Prescribed Drugs
1927(d)(2) and 1935(d)(2)

1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit -Part D.

The following excluded drugs are covered:

☐a) Agents used for anorexia, weight loss, weight gain (Only legend products that are not CNS stimulants are covered eg. Xenical)

☐b) Agents when used to promote fertility

☒c) Agents when used for the symptomatic relief cough and colds (Only legend products are covered)

☒d) Prescription vitamins and mineral products, except prenatal vitamins and fluoride

☒e) Selective Over-The-Counter (OTC) drugs will be covered as listed on the state's website and in the state's provider manual.

☐f) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific dmg categories below)

(The Medicaid agency lists specific category of drugs below)

No excluded drugs arc covered.

The state will cover agents when used for cosmetic purposes or hair growth only when the state has determined that use to be medically necessary

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State Agency Maryland

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

C. Rebates

1. The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.
2. The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.
3. A rebate agreement between the state and a drug manufacturer for drugs provided to Medicaid recipients, submitted to CMS on July 21, 2003 and entitled "State of Maryland Department of Health and Mental Hygiene Supplemental Rebate Agreement" has been authorized by CMS.
4. Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.
5. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with provisions of the national drug rebate agreement.
6. The State is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list pursuant to 42 U.S.C. section 1396r-8. Prior authorization will be provided with a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency situations.
7. Prior authorization will be established for certain drug classes, particular drugs or medically accepted indication for uses and doses in compliance with federal law.
8. The State will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with federal law .
9. CMS has authorized the State of Maryland to enter into The Optimal PDL Solution (TOPS$®). This Supplemental Drug Rebate Agreement was submitted to CMS on October 30, 2013 and has been authorized by CMS.

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12 b. Dentures (covered Services)

A. The Program only covers medically necessary dentures and denture related services solely for participants under the age of 21:

(1) Replacement dentures for participants who meet the requirements of A(3) on Page 23 will be covered only when:

(a) Dentures have been lost, broken, or stolen after 1 year of placement; or

(b) Adjustment, repair, relining, or rebasing of the patient's present denture does not make it serviceable.

(2) Rebasing is included in the 6 months of aftercare following denture placement and may not be provided more frequently than once every 2 years after that.

(3) The Program does not cover:

(a) Duplication of dentures;

(b) Immediate dentures; and

(c) Unilateral partial dentures replacing fewer than three teeth, excluding third molars.

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12 c. Prosthetic Devices (covered services)

Prosthetic devices as described in 42 CFR §440.120 are covered when medically necessary and furnished by Medicaid providers.

Prosthetic devices are replacement, corrective, or supportive devices prescribed by a physician to: artificially replace a missing portion of the body; prevent or correct physical deformity or malfunction; or support a weak or deformed portion of the body.

Devices covered include:

(a) Artificial eyes;
(b) Breast prostheses, including surgical brassiere;
(c) Upper and lower extremity, full and partial, to include stump cover or harnesses where necessary; and
(d) Replacement of prostheses;
(e) Cochlear implants; and
(f) Auditory osseointegrated devices.

Coverage of cochlear implants includes:

1. The initial implantation of:
   1) Bilateral cochlear implants for participants younger than 21 years of age;
   2) Unilateral cochlear implants for participants age 21 years old and older;
2. Post-operative evaluation and programming of the cochlear implant(s);
3. Aural rehabilitation services
4. A maximum of 238 disposable batteries for a unilateral cochlear implant per participant per 12-month period or 476 disposable batteries per 12-month period for a bilateral cochlear implant purchased not more frequently than every six months, and in quantities of 119 or fewer for a unilateral cochlear implant, or 238 or fewer for a bilateral cochlear implant;
5. Four replacement cochlear implant component rechargeable batteries per 12-month period for bilateral cochlear implants, and a maximum of two replacement rechargeable batteries for a unilateral cochlear implant per 12-month period;
6. Two cochlear implant replacement transmitter cables per 12-month period for bilateral cochlear implants and a maximum of one replacement transmitter cable for a unilateral cochlear implant;
7. Two cochlear implant replacement headset cables per 12-month period for bilateral cochlear implants and a maximum of one replacement headset cable for a unilateral cochlear implant;
8. Two replacement cochlear implant transmitting coils per 12- month period for bilateral cochlear implants, and a maximum of one replacement transmitting coil for a unilateral cochlear implant.
9. Cochlear implant audiology services and external components provided less than 90 days after the surgery or covered through initial reimbursement for the implant and the surgery;
10. Replacement of cochlear implants and device components that have been lost, stolen, or damaged beyond repair, after all warranties have expired;
11. Repairs and replacements that take place after all warranties have expired;
12. Additional cochlear implants, device components, or supplies determined to be medically necessary by the Department or its Designee.

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12 c. Prosthetic Devices (covered services continued)

Coverage of auditory osseointegrated devices includes:

1. The initial implantation of:
   1) Bilateral auditory osseointegrated devices for participants younger than 21 years of age;
   2) Unilateral auditory osseointegrated device for participants age 21 years old and older;
2. Non-implantable or softband device or devices that are medically necessary;
3. Evaluation and programming of the auditory osseointegrated device(s); and
4. A maximum of 76 disposable batteries per participant per 12-month period for a unilateral osseointegrated devices, or 152 batteries per participant per 12-month period for bilateral auditory osseointegrated devices purchased from the Department not more frequently than every six months, and in quantities of 38 or fewer for unilateral device, or 76 or fewer for a bilateral device;
5. Replacement of auditory osseointegrated device components that have been lost, stolen, or damaged beyond repair, after all warranties have expired;
6. Repairs and replacements that take place after all warranties have expired;
7. Additional auditory osseointegrated devices, device components, or supplies determined to be medically necessary by the Department or its Designee.

Preauthorization is required for the following:

1. Certain cochlear implant devices and replacement components;
2. All auditory osseointegrated devices; and
3. Repairs of cochlear implant devices and auditory osseointegrated devices exceeding $500.

Preauthorization is valid:

1. For services rendered or initiated six months from the date the preauthorization was issued; and
2. If the patient is an eligible participant at the time the service is rendered.

The following written documentation shall be submitted by the provider to the Department or its Designee with each request or preauthorization of cochlear implants, or auditory osseointegrated devices:

1. Audiology report documenting medical necessity of the cochlear implants, or auditory osseointegrated devices;
2. Interpretation of the audiogram; and
3. For initial hearing amplification device requests only, a medical evaluation by a physician supporting the medical necessity of the cochlear implants or auditory osseointegrated devices within six months of the preauthorization request.

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Program	Limitations
12. D. Eyeglasses	A. Limiting covered services to those ordered as a result of a full or partial periodic or interperiodic screen under the EPSDT Program and provided to individuals under 21, the Program places the following specific restrictions upon covered services: 1. Coverage is limited to eyeglasses which have first quality, impact resistant lenses, except in cases where prescription requirements cannot be met with impact resistant lenses, and frames which are made of fire resistant, first-quality material; 2. Subject to item 3 below, coverage is limited to a maximum of one pair per year, unless the time limitations are waived by the Department, based on medical necessity; 3. In order to be entitled to receive eyeglasses, a recipient shall meet at least one of the following conditions: a. The recipient requires a diopter change of at least 0.50; b. The recipient requires a diopter correction of less than 0.50 and this has been preauthorized according to section B below, based on medical necessity; c. The recipient's present eyeglasses have been damaged to the extent that they affect visual performance and cannot be repaired to affective performance standards, or are no longer usable due to a change in head size or anatomy; d. The recipient's present eyeglasses have been lost or stolen.

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Program	Limitations
(Continued) 12. D. Eyeglasses	4. The following are not covered: a. Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients 21 years old and older; b. Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients which were not ordered as a result of a full or partial EPSDT screen; c. Repairs, except when repairs to eyeglasses are cost effective compared to the cost of replacing with new glasses. d. Combination or metal frames except when required for proper fit; e. Cost of travel by the provider; f. A general screening of a Medical Assistance population; g. Visual training sessions which do not include orthoptic treatment; h. Routine adjustments.
Services that require preauthorization	A. The following services require written preauthorization: 1. Specified eyeglasses; 2. Optometric examinations to determine the extent of visual impairment or the correction required to improve visual acuity before expiration of the normal time limitations; 3. Replacement of eyeglasses due to medical necessity or because the eyeglasses were lost, stolen, or damaged beyond repair before expiration of the normal time limitations;

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Program	Limitations
Services that require preauthorization (continued)	4. Contact lenses; 5. Sub-normal vision aid examination and fitting; 6. Orthoptic treatment sessions; 7. Plastic lenses costing more than equivalent glass lenses unless there are six or more diopters of spherical correction or three or more diopters of astigmatic correction; 8. Absorbtive lenses, except cataract; 9. Ophthalmic lenses or optical aids when the diopter correction is less than: a. –0.50 D. sphere for myopia in the weakest meridian, b. +0.75 D. sphere for hyperopia in the weakest meridian, c. +0.75 D. additional for presbyopia, d. ±0.75 D. cylinder for astigmatism, e. A change in axis of 5° for cylinders of 1.00 diopter or more, f. A total of 4Δ (prism diopters) lateral or a total of 1Δ vertical. B. Preauthorization is issued when: 1. Program procedures are met; 2. Program limitations are met;

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Program	Limitations
Services that require preauthorization (continued)	3. The provider submits to the Department adequate documentation demonstrating that the service to be preauthorized is medically necessary (medically necessary means that the service or benefit is: (a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability, or health condition; (b) Consistent with current accepted standards of good medical practice; (c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and (d) Not primarily for the convenience of the consumer, family or provider.) C. Preauthorization is valid only for services rendered or initiated within 60 days of the date issued. D. Preauthorization normally required by the Program is waived when the service is covered and approved by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing. Non-Medicare claims require preauthorization according to§§A-C.

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

C. Diagnostic Services Environmental Lead Investigations

Provider Requirements:

A Lead Paint Risk Assessor shall have:

A. Been an accredited Lead Paint Inspector Technician for at least 1 year; and
B. Satisfied one of the following:
    a. Conducted at least 20 lead-based paint inspections at separate residential units, public buildings, or commercial properties; or
    b. Conducted at least five lead-based paint inspections under COMAR 26.16.05.09 and .10 and 15 lead dust inspections from at least 15 separate residential units, public buildings, or commercial properties.
C. Successfully completed the Lead Paint Risk Assessor training, with at least 14 hours of instruction for the initial course, covering the following topics:
    a. Epidemiology of lead exposures;
    b. Lead toxicity;
    c. Potential relationships between observed conditions and lead exposures;
    d. Lead paint disclosure requirements for real estate transactions;
    e. In-place management of lead paint;
    f. Remodeling and modernization; and
    g. Sampling for other sources of lead exposure found in soil and drinking water.
D. Received, as proof of training and accreditation, an identification card and a certificate indicating an expiration date which is 24 months following the accreditation date.
E. If applicable, applied for renewal of accreditation before the expiration date and successfully completed a Lead Paint Risk Assessor review course of at least 7 hours of instruction, covering topics included in the initial course, with specific emphasis on new requirements and procedures.

Covered Services:

A. The service includes on-site lead investigations for a housing unit designated as a child's home or primary residence.
B. The service is limited to Medicaid enrollees under age 21 with a documented elevated blood lead level of ≥ 5 µg/dL.

Limitations:

A. Investigations shall be performed by Lead Paint Risk Assessors who are accredited by the Maryland Department of the Environment.
B. Medicaid reimbursement is not available for any testing of substances (water, paint, etc.) which are sent to a laboratory for analysis due to Clinical Laboratory Improvement Amendments (CLIA) regulations, or for other lead abatement activities, items, materials or devices.

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

Preventive Services

A. Doula Services

General Description:
Doula services will be used to provide support for pregnant individuals throughout the perinatal period, which may improve birth-related outcomes. Pursuant to 42 C.F.R. Section 440.130(c), doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complications and/or promote the physical and mental health of the beneficiary.

Covered Services:

The Program shall cover doula services from the date of confirmed conception through the postpartum period, contingent on the client maintaining Medicaid eligibility.

Doula services means continuous physical, emotional, and informational support provided to the birthing parent throughout the prenatal period, labor and delivery, and postpartum periods, by a certified doula, including:

1. Information about the childbirth process;
2. Emotional and physical support provided at perinatal visits, and during labor and delivery which may include:
    a. Prenatal coaching;
    b. Person-centered care that honors cultural and family traditions; and
    c. Teaching and advocating on behalf of the birthing parent during appointment visits, hospitalization, and delivery;
3. Evidence-based information on general health practices pertaining to pregnancy, childbirth, postpartum care, newborn health, and family dynamics;
4. Emotional support, physical comfort measures, and information to the birthing parent to enable the birthing parent to make informed decisions pertaining to childbirth and postpartum care, and other issues throughout the perinatal period;
5. Support for the whole birth team including a birthing parent's partner, family members, and other support persons;
6. Evidence-based information on infant feeding to supplement, but not in lieu of, the services of a lactation consultant;
7. General breastfeeding guidance and resources;
8. Infant soothing and coping skills for the new parents; and

9. Facilitation of access to community or other resources that can improve birth-related outcomes such as ongoing home visiting services; transportation; housing; alcohol, tobacco and drug cessation; WIC, SNAP, and intimate partner violence resources.

Qualified Provider Specifications:

Doula services shall be provided by qualified individuals who:

1. Are at least 18 years of age;
2. Maintain up to date certification through a doula certification program approved by Maryland Medicaid; and
3. Have and maintain adequate liability insurance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

Preventive Services

B. Home Visiting Services

General Description:
Home visiting services will be used to provide support for pregnant individuals throughout the perinatal period, which may improve birth-related outcomes, as well as infant and child health outcomes. Pursuant to 42 C.F.R.Section 440.130(c), home visiting services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complications and/or promote the physical and mental health of the beneficiary.

Covered Services:

1. The covered service is a home visiting benefit for pregnant and parenting individuals by specially trained professionals to provide informational support and facilitate screening and care coordination needed to support healthy outcomes through pregnancy and beyond as determined by medical necessity.
2. Home visiting services will be covered when delivered in accordance with one of the State's approved evidence-based models.

3. Service components for the State's approved evidence-based models can include:
    a. Prenatal home visits:
        i. Monitoring for high blood pressure or other complications of pregnancy ,
        ii. Diet and nutritional education;
        iii. Stress management;
        iv. Sexually Transmitted Diseases (STD) prevention education;
        v. Tobacco use screening and cessation education;
        vi. Alcohol and other substance misuse screening and counseling;
        vii. Depression screening;
        viii. Domestic and intimate partner violence screening and education;
        ix. Pregnancy education; and
        x. Facilitation of access to community or other resources that can improve birth-related outcomes such as transportation; housing; alcohol, tobacco and drug cessation; WIC and SNAP, and intimate partner violence resources.
    b. Postpartum home visits:
        i. Diet and nutritional education;

ii. Stress management;
iii. Sexually Transmitted Diseases (STD) prevention education;
iv. Tobacco use screening and cessation education;
v. Alcohol and other substance misuse screening and counseling;
vi. Depression screening;
vii. Postpartum depression education;
viii. Domestic and intimate partner violence screening and education;
ix. Breastfeeding support and education;
x. Guidance and education with regard to well woman visits to obtain recommended preventive services;
xi. Medical assessment of the postpartum mother and infant, as determined by medical necessity
xii. Child development education;
xiii. Maternal-infant safety assessment and education (e.g. safe sleep education for Sudden Infant Death Syndrome (SIDS) prevention);
xiv. Counseling regarding postpartum recovery, family planning, and needs of a newborn;
xv. Assistance for the family in establishing a primary source of care and a primary care provider (i.e. ensure that the mother/ infant has a postpartum/newborn visit scheduled);
xvi. Parenting skills, parent-child relationship building, and confidence building; and
xvii. Facilitation of access to community or other resources that can improve birth-related outcomes such as transportation; housing; alcohol, tobacco and drug cessation; WIC and SNAP, and intimate partner violence resources.

c. Infant Home Visits:
i. Child developmental screening at major developmental milestones;
ii. Parenting skills, parent-child relationship building, and confidence building;
iii. Breastfeeding support and education; and
iv. Facilitation of access to community or other resources that can improve birth-related outcomes such as transportation; housing; alcohol, tobacco and drug cessation; WIC and SNAP, and intimate partner violence resources.

Qualified Provider Specifications:
Home visiting services shall be provided by program sites who are fully accredited or meet fidelity standards as designated by their national program offices. Home visitors employed by these accredited programs must meet national program education and experience standards, and receive comprehensive program specific training, in order to become qualified practitioners able to provide all necessary prenatal, postpartum or infant home visiting services as indicated by medical necessity.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, & i.e., other than those provided elsewhere in this plan. d. Rehabilitation Services e. Mobile Treatment Services (MTS)	A.- Services are to be delivered by programs organized to provide intensive, assertive mental health treatment and support services delivered on or off site and are limited to those specified in COMAR 10.21.19.06 and include: psychiatric evaluation, diagnosis and treatment; medication prescription, medication administration, and the monitoring of medication; interactive therapies (e.g. individual and group therapies) crisis intervention /emergency services; psychological services; individual treatment planning, health promotion and training; coordination and linkage of the services identified in the patient's individual treatment plan; and independent living skills assessment and training. B. Service delivery is limited to the following qualified staff: 1. A program director who: (a) Is a mental health professional; (b) Is available to provide MTS administration and supervision: (i) If fewer than 40 individuals are receiving services, for an amount of time calculated on the basis of ½ hour per week for individual who is receiving services, or (ii) If 40 or more individuals are receiving services, 20 hours per week; (c) Is responsible for operational oversight for, at a minimum: (i) Fulfilling the administrative requirements under COMAR 10.21.17 and the day to day

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive & i.e. other than those provided elsewhere in this plan. d. Rehabilitation Services e. Mobile Treatment Services	clinical responsibilities for MTS, (ii) Recruiting, hiring, training and supervising staff, (iii) Developing and implementing the budget, (iv) Keeping the governing body informed of, at a minimum, the program's approval status and performance. (v) Ensuring that MTS are available to the individual, if needed, 24 hours per day, 7 hours per week and establishing on-call responsibilities, (vi) Ensuring continuity of care during the time that an individual is receiving MTS be evaluating caseloads and coordinating staff schedules, and (d) May carry out any of the clinical and training duties of a mental health professional or other MTS staff. 2. A psychiatrist who: (a) Is involved, for an amount of time calculated on the basis of at least ¼ hour per week for each individual who is receiving services, in: (i) Consultation with MTS staff, and (ii) Evaluating and providing MTS; (b) Ensures that MTS are provided in accordance with accepted standards of medical practice; (c) Following a screening evaluation of an individual completed under COMAR 10.21.19.04B and has an initial face to face contact with the individual, as required under COMAR 10.21.19.05A. This is done to:

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive & i.e. other than those provided elsewhere in this plan. d. Rehabilitation Services e. Mobile Treatment Services	(i) Formulate and document, as well as diagnosis or affirm the psychiatric diagnosis that has been entered in the individual's MTS medical record, (ii) Assess medical needs (iii) Confirm the medical necessity of MTS, (iv) When appropriate, order MTS for the individual, and (v) Authorize the initial ITP; (d) Is responsible for, at a minimum, the following: (i) Evaluating the individual, face-to-face, at least every three months, (ii) As required under COMAR 10.21.19.05C, participates in the development, required periodic review and signing of an individual's ITP, (iii) Prescribing medication and providing other medication services under COMAR 10.21.19.06A, (iv) Providing the appropriate treatment indicated in the individual's ITP, and (v) Supervising psychiatric residents, if any, who provide MTS, including, if duties are delegated, providing, at least monthly, a review of the status of the individuals whom the resident is treating; (iv) Providing the appropriate treatment indicated in the individual's ITP, and

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive & i.e. other than those provided elsewhere in this plan. d. Rehabilitation Services e. Mobile Treatment Services	(v) Supervising psychiatric residents, if any, who provide MTS, including, if duties are delegated, providing, at least monthly, a review of the status of the individuals whom the resident is treating; (e) May delegate the following duties to a third or fourth year resident of an accredited program in psychiatry: (i) Except for the initial 3 month evaluation, the periodic evaluations as required under COMAR 10.21.19.08B(4)(a), (ii) Participation in the development, required periodic review and signing of an individual's ITP, required under COMAR 10.21.19.08B(4)(b), (iii) If the resident is a licensed physician, prescribing medication and providing other medication services, as required under COMAR 10.21.19.08B(4)(c), and (iv) As required under COMAR 10.21.19.08B(4)(d) providing the appropriate treatment indicated in the individual's ITP; and (f) May not delegate: (i) The initial psychiatric evaluation, (ii) Formulation and documentation of the psychiatric diagnosis or affirmation of a psychiatric diagnosis that has been entered in the individual's MTS medical record, or (iii) Ordering of MTS for an individual;

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive & i.e. other than those provided elsewhere in this plan. d. Rehabilitation Services e. Mobile Treatment Services	3. A registered nurse who: (a) Is licensed under the provisions of Health Occupations Article, Title 8, Annotated Code of Maryland; (b) Participates in MTS for an amount of time calculated on the basis of at least 1 hour per week for each individual who is receiving services; and (c) As permitted under Health Occupations Article, Annotated Code of Maryland, performs assigned duties that the nurse is credentialed and privileged to perform, including but not limited to: (i) Medication administration and other medication services outlined in COMAR 10. 21.18.06 and (ii) Health promotion and training, as described in COMAR 10.21.18.06C; 4. At least one social worker who: (a) Is licensed under the Provisions of Health Occupations Article, Title 19, Annotated Code of Maryland; and (b) As permitted under Health Occupations Article, Annotated Code of Maryland, performs assigned duties the social worker is credentialed and privileged to perform, including but not limited to: (i) Interactive therapies, as outlined under COMAR 10.21.19.06D,

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive & i.e. other than those provided elsewhere in this plan.	(ii) Support, linkage and advocacy outlined in COMAR 10.21.19.06F, (iii) Discharge and transition services as outlined in COMAR 10.21.19.07; and
d. Rehabilitation Services	5. At least one mental health professional who: (a) May include the social workers, nurses and Physicians, and.
e. Mobile Treatment Services (MTS)	(b) As permitted under Health Occupations Article, Annotated Code of Maryland, performs assigned duties that the mental health professional is credentialed and privileged to perform, including but not limited to: (i) Conducting the screening evaluation required under COMAR 10.21.19.04B and participating in the initial psychiatric evaluation required under COMAR 10.21.19.05A, (ii) According to the provisions in COMAR 10.21.19.05C, reviewing and signing an individual's ITP, (iii) Have the duties outlined in 10.21.19.06 & .07, the mental health professional is licensed or credentialed and privileged to perform, (iv) When credentialed and privileged by the program to do so, functioning as the treatment coordinator for individuals who are receiving MTS, (v) Supervises direct service providers, and (vi) Assures that, before the provision of MTS and, as needed, on an in-service basis, appropriate training is provided to direct service providers.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, & provided elsewhere in this plan. d. Rehabilitation Services f. Mobile Treatment Services (Continued)	6. Additional Staff. As needed, based on the number of individuals served, the program director may include on the MTS staff direct service providers as detailed in COMAR 10.21.19.10 C. Providers of Mobile Treatment Service are limited to those that are organized to deliver mobile treatment services and that are able to comply with regulations established by the Single State Agency. D. Services must be determined by a physician to be medically necessary and must be supported by an individual treatment plan. E. Vocational counseling, vocational training, at a classroom or job site, and academic/remedial education services are not reimbursable. F. Services provided to or for the primary benefit of individuals other than the eligible client are not eligible for reimbursement. G. Services delivered by telephone are not reimbursable. H. Services provided in an Institution for Mental Disease are not reimbursable.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, & i.e., other than those provided elsewhere in this plan. d. Rehabilitation Services e. Mobile Treatment Services	I. Services do not include: 1. Investigational and experimental drugs and procedures; 2. Rehabilitation services provided to hospital inpatients; 3. Rehabilitation visits solely for the purpose of either or both of the following: a. Prescription, drug or supply pick-up, or collection of laboratory specimens; or b. Interpretation of laboratory tests or panels. 4. Injections and visits solely for the administration of injections, unless medical necessity and the recipient's inability to take appropriate oral medications are documented in the patient's medical record, and 5. Separate reimbursement to any employee of a rehabilitation services program for services provided through a rehabilitation service program when the rehabilitation services program has been reimbursed directly.

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F. Administration of COVID-19 Vaccinations

Covered Services:

1. The covered service is the administration of vaccination for COVID-19.

Provider Qualifications:

1. In order to receive reimbursement for the administration of vaccination for COVID-19, the provider listed in paragraph (2) must be actively enrolled with the Maryland Medical Assistance Program in good standing or provide services under the direction of an actively enrolled Maryland Medical Assistance Program provider in good standing.

2. Service delivery is limited to:
    a. Pharmacy interns and pharmacy technicians are able to function within their scope of practice when registered with the Maryland Board of Pharmacy. Pharmacy interns and pharmacy technicians must be registered with the Maryland Board of Pharmacy and working under the supervision of a licensed pharmacist. Pharmacies are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations;

    b. Paramedics legally authorized by the State of Maryland Institute for Emergency Medical Services Systems based on the following criteria: Neonatal Resuscitation Program (NRP) certification; successful completion of a Maryland ALS licensing protocol exam; and affiliation with an ALS EMS practicing or delivering services under the direction of:
        i. an EMS Service Transporter,
        ii. a qualified physician,
        iii. a local health department under the direction of the health officer who is a physician or the health officer's deputy who is a physician, or
        iv. a hospital or health system in Maryland under the direction of a physician, nurse practitioner, or physician assistant;

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G. Medication Therapy Management (MTM)

Covered Services:

1. The Medication Therapy Management (MTM) services when provided in an outpatient setting by a licensed and legally authorized pharmacist in the state in which the service is provided.
2. The MTM consultation is structured to reduce the risk of adverse events and ensure optimum therapeutic outcomes for targeted patients through improved medication use with disease-state specific education, counseling, and medication review related to treatments including drug therapy, laboratory tests, or medical devices provided by licensed and practicing pharmacists.
3. These services will be solely based on referrals. The Department will determine eligibility and refer patients based on diagnosis and use of medications.

Limitations:

Under the MTM Services, the following are not covered:

1. MTM group visits.
2. Broken or missed appointments.
3. Time required for preparation of the MTM visits including completion of forms or reports.
4. Services rendered by mail or otherwise not one-to-one.
5. Any participant eligible for Medicare Part D.
6. Participants who reside in a setting where medications are managed/administered by facility staff.
7. Services not identified by the Department as medically necessary or covered.
8. More than one patient visits per day for MTM services.
9. Injections and visits solely for the administration of injections.
10. Services prohibited by the Maryland Board of Pharmacy.

Provider Qualifications:

1. In order to receive reimbursement for Medication Therapy Management, the pharmacist must be actively enrolled with the Maryland Medical Assistance Program in good standing and they are operating within their lawful scope of practice as defined by State Law.

RESERVE FOR FUTURE USE

RESERVE FOR FUTURE USE

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, & i.e., other than those provided elsewhere in this plan. d. Rehabilitation Services III. Psychiatric Rehabilitation Programs	A. Services may be provided to an individual or in a small group at the program site or at an off-site location appropriate to the individual's needs, and are limited to: 1. Psychiatric rehabilitation assessment of the patient's strengths, skills, and needs in the areas of independent living, daily living skills, housing, mobility, interpersonal relationships, leisure activities, self-administration and management of medications, or any other areas that may pose a challenge to the individual's successful rehabilitation. 2. Individual rehabilitation planning based upon the psychiatric rehabilitation assessment which is prepared in conjunction with the consumer or the consumer's legal guardian and which includes, at a minimum, (a) the individual's presenting needs, strengths, and rehabilitation expectations and responsibilities, (b) a description of needed and desired program services and interventions, and staff responsible for implementation, (c) a description of how the needed and desired skills and supports will help the individual to choose an environment or remain in the environment of choice, (d) rehabilitation goals in measurable terms, and target dates for each goal, and

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, & i.e., other than those provided elsewhere in this plan. d. Rehabilitation Services III. Psychiatric Rehabilitation Programs (continued)	(e) when appropriate, identification of, recommendations for, and collaboration with, other services to support the individual's rehabilitation, including but not limited to mental health treatment, residential services, and somatic care. 3. Psychiatric rehabilitation services which develop or restore: (a) self care skills, including personal hygiene, grooming, nutrition, dietary planning, food preparation, and self-administration of medication; (b) social skills, including community integration activities, developing natural supports, and developing linkages with and supporting the individual's participation in community activities; and (c) independent living skills. 4. Medication administration and monitoring. 5. Health promotion and training as indicated in the patient's individual rehabilitation plan and may include areas such as nutrition, exercise, dental care, and substance abuse, injury, and illness prevention. 6. Psychiatric crisis services include intensive support and assistance, the provision of information regarding services which the patient needs.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, & i.e., other than those provided elsewhere in this plan. d. Rehabilitation Services III. Psychiatric Rehabilitation Programs (continued)	B. Required staff, who are authorized to provide services, include: 1. A program director, who meets the qualifications of COMAR 10.21.21.08§F(1); 2. One or more rehabilitation specialists, as required by COMAR 10.21.21.08§D, §E, or §F, who: (a) is either a mental health professional or a: (i) creative arts therapist who has a master's degree and who is registered or certified by the American Art Therapy Association, American Dance Therapy Association, National Association of Music Therapy, or American Association for Music Therapy, (ii) rehabilitation counselor who has a master's degree in rehabilitation counseling, psychiatric rehabilitation, vocational rehabilitation, or who is currently certified by the Commission on Rehabilitation Counselor Certification, or (iii) therapeutic recreations specialist who has a master's degree in therapeutic recreation or who is registered as a therapeutic recreation specialist by the National Therapeutic Recreation Society;

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, & i.e., other than those provided elsewhere in this plan. d. Rehabilitation Services III. Psychiatric Rehabilitation Programs (continued)	(iv) bachelors prepared Certified Psychiatric Rehabilitation Practitioner currently certified by the International Association of Psychosocial Rehabilitation Services (IASPRS) and 3. Direct service staff, sufficient in number to meet the rehabilitation needs of the enrolled patients, who: (a) at a minimum, have: (i) a high school equivalency diploma, unless exempted by the governing body and program director, and (ii) sufficient qualifications, knowledge, or experience to work with individuals served by the program; and (b) are responsible for implementing the rehabilitation activities outlined in the individual's IRP. 4. Volunteers, Students, and Trainees. The program may use volunteers, students, and trainees according to the provisions of COMAR 10.21.17.09E. C. Providers of Psychiatric Rehabilitation Program services limited to those that are organized to deliver psychiatric rehabilitation program services, which comply with COMAR 10.21.16, 10.21.17, and 10.21.21, as well as regulations established by the Single State Agency.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, & i.e., other than those provided elsewhere in this plan. d. Rehabilitation Services III. Psychiatric Rehabilitation Programs (continued)	D. Services must be preauthorized by the Administration's administrative services organization (ASO), according to the provisions of COMAR 10.21.17.02-1A. E. Services provided to or for the primary benefit of individuals other than the eligible client are not reimbursable. F. Vocational counseling, vocational training at a classroom or a job site, and academic/remedial educational services are not reimbursable. G. Services delivered by telephone are not reimbursable. H. Services provided in an Institution for Mental Disease are not reimbursable. I. Services do not include: 1. Investigational and experimental drugs and procedures. 2. Services denied by Medicare as not medically justified. 3. Rehabilitation services provided to hospital inpatients. 4. Rehabilitation visits solely for the purpose of either or both of the following: (a) prescription, drug or supply pick-up, or collection of laboratory specimens; or (b) interpretation of laboratory tests or panels.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, & i.e., than those provided elsewhere in this plan. d. Rehabilitation Services III. Psychiatric Rehabilitation Programs (continued)	5. Injections and visits solely for the administration of injections, unless medical other necessity and the recipient's inability to take appropriate oral medications are documented in the patient's medical record; 6. Separate reimbursement to any employee of a rehabilitation services program for services provided through a rehabilitation service program when the rehabilitation services program has been reimbursed directly; and 7. An on-site psychiatric rehabilitation program visit on the same day that the recipient receives medical day care services under COMAR 10.09.07.

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PROGRAM

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

d. Rehabilitative services

IV. Adult medical day care services

A. Adult medical day care services are covered for Medicaid recipients age 16 or older who require the level of services provided in a nursing facility. Participants must attend for a minimum of 4 hours in order for the provider to be paid for a day of care.

B. Covered services include medical services, nursing, physical and occupational therapy, personal care, meals/nutrition services, social work services, activity programs, and transportation.

C. Provider of medical day care services must be licensed as adult day care centers. Providers must have a full time registered nurse, full or part time social worker, full or part time activity coordinator, personal care attendants, staff physician, food service, transportation service and appropriate rehabilitation staff.

LIMITATIONS

1. Services to recipients who are not certified by the State's utilization control agent as needing nursing facility services.

2. Services not authorized on a plan of care by a licensed physician.

3. Services for which payment is made directly to a provider of than a medical day care facility.

4. Billing time limitations:

a. The Department may not reimburse claims received by the Program for payment more than 9 months after the date of service.

b. Medicare claims. For any claim initially submitted to Medicare and for which services have been:

(i) Approved, requests for reimbursement shall be submitted and received by the Program within 0 months of the date of service 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and

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PROGRAM	
Adult medical day care services	(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 9 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 9 months of the earliest date of service. d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 9-month period, or within 60 days of rejection, whichever is later. e. Claims submitted after the time limitations because of retroactive eligibility determination shall be considered for payment if received by the Program within 9 months of the date on which eligibility was determined.

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13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan.
    d. Rehabilitative Services
        V. Community-Based Substance Use Disorder Services

Community-based substance use disorder services are provided in non-hospital community-based settings. From October 1, 2020 through September 30, 2025, medication assisted treatment (MAT) to treat opioid use disorder (OUD) as defined at section 1905(ee)(1) of the Social Security Act is covered exclusively in Supplement to Attachment 3.1-A for 1905(a)(29).

Covered Services:

A. Comprehensive substance use disorder assessment:

(1) *Definition of Service:* A comprehensive substance use disorder assessment is a process of determining a participant's current health status and relevant history in areas including substance use, mental health, social supports, and somatic health. Providers use a comprehensive assessment to establish the type and intensity of services participants will need to adequately address their substance use disorder.

(2) *Service Requirements:* Comprehensive substance use disorder assessment at a minimum shall be reviewed and approved by a licensed physician or licensed practitioner of the healing arts, within the scope of his or her practice under State law, and shall include an assessment of drug and alcohol use, as well as substance use disorder treatment history. It shall also include referrals for physical and mental health services; and a recommendation for the appropriate level of substance use disorder treatment.

B. Group and individual substance use disorder counseling services

(1) *Definition of Service:* Individual and group counseling sessions involve evidence-based psychotherapeutic interventions. Cognitive- behavioral, motivational, and insight-based techniques are used according to each participant's needs. The therapeutic style is client-centered and flexible. Treatment usually involves a combination of individual and group counseling. The primary goals of treatment are to:

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- Develop skills to enable individuals to abstain from all non-prescribed psychoactive substances;
- Develop relapse prevention strategies through family and/or other support networks; and
- Engage participants in long-term recovery strategies.

(2) *Service Requirements:* Before providing services described in this section, the provider shall develop a written individualized treatment plan, in conjunction with the participant based on the comprehensive assessment. This plan which shall be updated as clinically appropriate, shall be reviewed and approved by a licensed physician or licensed practitioner of the healing arts within the scope of his or her practice under State law, and shall include:

- An assessment of the participant's individual needs; and
- The participant's treatment plan goals.

C. Intensive Outpatient Services

(1) *Definition of Service:* Intensive Outpatient service is a more intense form of treatment than group and individual counseling. This service is either a step-down treatment from more intensive, often inpatient-based care or a step-up when a participant is in need of more intensive services. While less intensive than inpatient care, it provides a substantial range of treatment intensity and bridges the gap between medically managed or medically monitored intensive inpatient treatment and traditional outpatient services of low intensity. Participants participate within an ambulatory therapeutic setting while residing in a separate location.

(2) *Service Requirements:* Before providing Intensive Outpatient Services as described in this section, the provider must develop a written individualized treatment plan, in conjunction with the participant based on the comprehensive assessment. This plan shall be updated as clinically appropriate, shall be reviewed and approved by a licensed physician or licensed practitioner of the healing arts, within the scope of his or her practice under State law. The individualized treatment plan shall include the following requirements:

- An assessment of the participant's individual needs; and
- The participant's treatment plan goals; and
- Specific interventions for meeting the treatment plan goals, which reflect the amounts frequencies and intensities appropriate to the objective of the treatment.

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D. Partial Hospitalization

(1) *Definition of Service:* Partial Hospitalization treatment is a short-term, outpatient psychiatric treatment service that parallels the intensity of services provided in a hospital, including medical and nursing supervision and interventions. Partial Hospitalization is a more intense form of treatment than Intensive Outpatient Services and serves as an alternative to inpatient care when the participants can safely reside in the community.

Participants who require at least 20 hours of structured outpatient treatment per week, delivered in half or full day sessions, are eligible to receive Partial Hospitalization services.

(2) *Service Requirements:* Before providing Partial Hospitalization Services, the provider must develop a written individualized treatment plan, in conjunction with the participant based on the comprehensive assessment. This plan shall be updated as clinically appropriate, reviewed and approved by a licensed physician or licensed practitioner of the healing arts, within the scope of his or her practice under State law, and shall include the following requirements:

- An assessment of the participant's individual needs; and
- The participant's treatment plan goals; and
- Specific interventions for meeting the treatment plan goals which reflect the amounts frequencies and intensities appropriate to the objective of the treatment.

E. Opioid Maintenance Therapy:

Service moved to 1905(a)(29) Medication Assisted Treatment Supplement to Attachment 3.1-A. Reserve for future use. From October 1, 2020 through September 30, 2025, medication assisted treatment (MAT) to treat opioid use disorder (OUD) as defined at section 1905(ee)(1) of the Social Security Act is covered exclusively in Supplement to Attachment 3.1-A for 1905(a)(29).

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F. Medication assisted treatment services for participants with substance use disorders other than opioid use disorder:

From October 1, 2020 through September 30, 2025, medication assisted treatment (MAT) to treat opioid use disorder (OUD) as defined at section 1905(ee)(1) of the Social Security Act is covered exclusively in Supplement to Attachment 3.1-A for 1905(a)(29).

(1) *Definition of Service:* Medication assisted treatment uses pharmacological interventions as part of a treatment program for participants with substance use disorders other than opioid use disorder. Medication assisted treatment includes:

- Point of care toxicology
- Periodic medications
- Periodic medication management visits for substance use disorder symptom reduction or withdrawal management.

(2) *Service Requirements:* Before providing medication assisted treatment, the provider must develop a written individualized treatment plan, in conjunction with the participant based on the comprehensive assessment. This plan shall be updated as clinically appropriate, reviewed and approved by a licensed physician or licensed practitioner of the healing arts, within the scope of his or her practice under State law, and shall include the following requirements:

- An assessment of the participant's individual needs; and
- The participant's treatment plan goals.

G. Ambulatory Withdrawal Management

(1) *Definition of Service:* Ambulatory Withdrawal Management is a service provided to acutely intoxicated participants to manage withdrawal syndromes. Ambulatory Withdrawal Management includes:

- Physical examinations.
- Initial and periodic comprehensive substance use disorder assessments including an assessment of drug and alcohol use, as well as substance use disorder treatment history. It shall also include referrals for physical and mental health services; and a recommendation for the appropriate level of substance

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- Managing withdrawal symptoms including administration and monitoring of medications.
- Monitoring of vital signs.
- Assisting in motivating the individual to participate in an appropriate treatment program for alcohol and other drug dependence.

(2) *Service Requirements:* Before providing Ambulatory Withdrawal Management services, the provider must develop a comprehensive assessment. This plan shall be reviewed and approved by a licensed physician or licensed practitioner of the healing arts, within the scope of his or her practice under State law, shall include all of the following requirements:

- An assessment of the participant's individual needs; and
- The participant's treatment plan goals.

H. Peer Recovery Support Services

(1) *Definition of Service:* Peer recovery support services are a set of non-clinical activities provided by individuals in recovery from behavioral health concerns, including substance use or addictive disorders or mental health concerns, who use their personal, lived experiences and training to support other individuals with substance use disorders. Services may include, but are not limited to:

- Participation in development of recipient's treatment plan
- Supporting recipient through goal-setting and skill-building
- Providing culturally competent care
- Facilitating peer support group
- Providing referrals to additional crisis services, community-based supports, or other medically necessary services on a need basis

(2) *Service Requirements:* Peer recovery support services must be included as part of a written individualized treatment plan that includes specific individualized goals. Services provided by certified peer recovery support specialists must be overseen by:

- A registered peer supervisor who is certified by the Maryland Addictions and Behavioral Health Professionals Certification Board or a comparable association with equivalent requirements approved by the Behavioral Health Administration; or

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- Until September 1, 2023, a licensed mental health practitioner or a certified alcohol and drug counselor who is approved to supervise by the relevant licensing board may serve as the peer supervisor. -

Practitioner and Provider Qualifications:

A. Certified Peer Recovery Support Specialist Qualifications:
(1) Certified Peer Recovery Support Specialists must be certified by the Maryland Addictions and Behavioral Health Professionals Certification Board or a comparable association with equivalent requirements, approved by the Behavioral Health Administration.
(2) Peers must have training to ensure competency in the area of recovery oriented systems and in the principles and concepts of peer support roles.
(3) Peers must complete the continuing education requirements as set forth by the Behavioral Health Administration or their designee.
(4) Peers must self-identify as individuals with life experience of being diagnosed with behavioral health concerns, including substance use disorders, addictive disorders, or mental health concerns and be in recovery for at least two years.
(5) Peers must be at least eighteen (18) years of age.
(6) Peers must be employed by and render peer recovery support services through a licensed opioid treatment program, community-based SUD program, or federally qualified health center.

B. **Provider Qualifications**

(1) **Community-based Outpatient Treatment Providers:**

- Licensed by the designated state agency to provide SUD treatment services.
- Agencies providing MAT are required to employ or contract with licensed physicians, nurse practitioners, or physician's assistants operating under the supervision of a licensed physician.
- Agencies providing outpatient counseling services are required to employ or contract with licensed mental health practitioners in accordance with Attachment 3.1-A page 19-6.g. of the state plan..

(2) **Opioid Treatment Providers:**

- Defined in 1905(a)(29) Medication Assisted Treatment Supplement to Attachment 3.1-A. From October 1, 2020 through September 30, 2025,

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medication assisted treatment (MAT) to treat opioid use disorder (OUD) as defined at section 1905(ee)(1) of the Social Security Act is covered exclusively in Supplement to Attachment 3.1-A for 1905(a)(29).

- Opioid treatment providers are able to provide services for non-OUD treatment under professional license as designated by the state.

Limitations:

- All services require prior authorization by the Department or its designee prior to service delivery and all services are subject to approval based on medical necessity.

State of Maryland

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) MAT as described and limited in Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

State of Maryland

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) MAT as described and limited in Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

i) **Comprehensive assessment for participants with opioid use disorder:**

(1) *Definition of Service*: A comprehensive assessment is a process of determining a participant's current health status and relevant history in areas including opioid use, mental health, social supports, and somatic health. Providers use a comprehensive assessment to establish the type and intensity of services participants will need to adequately address their opioid use disorder.

(2) *Service Requirements:* Comprehensive assessment at a minimum shall be reviewed and approved by a licensed physician or licensed practitioner of the healing arts, within the scope of his or her practice under State law, and shall include an assessment of current opioid use and opioid use disorder treatment history. It shall also include referrals for physical and mental health services; and a recommendation for the appropriate service for opioid use disorder treatment.

ii) **Group and individual opioid use disorder counseling services:**

(1) *Definition of Service:* Individual and group counseling sessions involve evidence- based psychotherapeutic interventions. Cognitive- behavioral, motivational, and insight-based techniques are used according to each participant's needs. The therapeutic style is client-centered and flexible. Treatment

State of Maryland
1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) MAT as described and limited in Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

usually involves a combination of individual and group counseling. The primary goals of treatment are to:

- Develop skills to enable individuals to abstain from all opioids
- Develop relapse prevention strategies through family and/or other support networks; and
- Engage participants in long-term recovery strategies.

(2) *Service Requirements*: Before providing services described in this section, the provider shall develop a written individualized treatment plan, in conjunction with the participant based on the comprehensive assessment. This plan which shall be updated as clinically appropriate, shall be reviewed and approved by a licensed physician or licensed practitioner of the healing arts within the scope of his or her practice under State law, and shall include:

- An assessment of the participant's individual needs; and
- The participant's treatment plan goals.

iii) **Peer recovery support services for participants with opioid use disorder**

(1) *Definition of Service:* Peer recovery support services are a set of non-clinical activities provided by individuals in recovery from behavioral health concerns, including substance use or addictive disorders or mental health concerns, who use their personal, lived experiences and training to support other individuals with substance use disorders. Services may include, but are not limited to:

- Participation in development of recipient's treatment plan

State of Maryland

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) MAT as described and limited in Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

- Supporting recipient through goal-setting and skill-building
- Providing culturally competent care
- Facilitating peer support groups
- Providing referrals to additional crisis services, community-based supports, or other medically necessary services, on a need basis.

(2) *Service Requirements:* Peer recovery support services must be included as part of a written individualized treatment plan that includes specific individualized goals. Services provided by certified peer support specialists should be overseen by:

- A registered peer supervisor who is certified by the Maryland Addictions and Behavioral Health Professionals Certification Board or a comparable association with equivalent requirements approved by the Behavioral Health Administration; or
- Until September 1, 2023, a licensed mental health practitioner or a certified alcohol and drug counselor who is approved to supervise by the relevant licensing board may serve as the peer supervisor.

b) Please include each practitioner and provider entity that furnishes each service and component service.

i) **Comprehensive assessments for participants with an opioid use disorder are rendered by:**

(1) Opioid Treatment Programs (OTPs) utilizing appropriately licensed and certified alcohol and drug counselors, and

(2) Community-based outpatient treatment service providers

State of Maryland

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) MAT as described and limited in Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

utilizing appropriately licensed and certified alcohol and drug counselors.

ii) **Group and individual opioid use disorder counseling services are rendered by:**

(1) OTPs utilizing appropriately licensed and certified alcohol and drug counselors, and

(2) Community-based outpatient treatment service providers utilizing appropriately licensed and certified alcohol and drug counselors.

iii) **Peer recovery support services for participants with opioid use disorder are rendered by:**

(1) OTPs provide group and individual peer recovery support services utilizing certified peer recovery specialists, and

(2) Community-based outpatient treatment service providers provide group and individual peer recovery support services utilizing certified peer recovery specialists.

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

i) **Practitioner and Provider Qualifications:**

(1) Licensed and certified alcohol and drug counselors:

- Licensed clinical alcohol and drug Counselor: licensed by

State of Maryland

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) MAT as described and limited in Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

the State Board of Professional Counselors and Therapists

(2) Physicians: licensed by the Maryland Board of Physicians

(3) Physician assistants: licensed by the Maryland Board of Physicians

(4) Nurse practitioners: licensed by the Maryland Board of Nursing

(5) Registered nurses: licensed by the Maryland Board of Nursing

(6) Physicians, nurse practitioners, and physician's assistants: registered with the DEA with Schedule III authority to prescribe opioid medications or combinations of such medications that have been specifically approved by the Food and Drug Administration for that indication.

ii) **Community-based Outpatient Treatment Providers**:

(1) Licensed by the designated state agency to provide OUD treatment services.

(2) Providers that provide MAT must employ or contract with practitioners registered with the DEA with Schedule III authority to prescribe medications for the treatment of opioid use disorders.

(3) Providers that provide group and individual opioid use disorder counseling services are required to employ or contract with licensed clinical alcohol and drug counselors in accordance with practitioner qualifications in (c)(i) above.

iii) **Certified Peer Recovery Support Specialists:**

State of Maryland

1905(a)(29) Medication-Assisted Treatment

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) MAT as described and limited in Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

(1) Certified Peer Recovery Support Specialists must be certified by the Maryland Addictions and Behavioral Health Professionals Certification Board or a comparable association with equivalent requirements, designated by the Behavioral Health Administration or their designee.
(2) Peers must have training to ensure competency in the area of recovery oriented systems and in the principles and concepts of peer support roles.
(3) Peers must complete the continuing education requirements as set forth by the Behavioral Health Administration or their designee.
(4) Peers must self-identify as individuals with life experience of being diagnosed with behavioral health concerns, including substance use disorders, addictive disorders, or mental health concerns and be in recovery for at least two years.
(5) Peers must be at least eighteen (18) years of age.
(6) Peers must be employed by and render peer recovery support services through a licensed opioid treatment program, community-based SUD program, or federally qualified health center.

iv. Utilization Controls

_X_____The state has drug utilization controls in place. (Check each of the following that apply)

_X____Generic first policy

_X____Preferred drug lists

_X____Clinical criteria

_X____Quantity limits

_____The state does not have drug utilization controls in place

State of Maryland

1905(a)(29) Medication-Assisted Treatment

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) MAT as described and limited in Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

- All services require prior authorization by the Department or its designee prior to service delivery and all services are subject to approval based on medical necessity.
- The Department has quantity limits over time and daily maximum dose limits for several of the MAT drugs. For a complete listing of these limitations please visit this address: https://mmcp.health.maryland.gov/pap/docs/QL.pdf.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. Preventive Services
Prevention Services
C. Community Violence Prevention Services

General Description:
Community violence prevention services are provided by a certified violence prevention professional to a Medicaid participant who has been exposed to community violence or has received treatment for an injury sustained as a result of an act of community violence. The service is designed to prevent further impacts of community violence, avoid future community violence, prolong life, and promote the participant's health. In accordance with 42 C.F.R. § 440.130(c), these services are recommended by a physician or other qualified licensed practitioner of the healing arts within the practitioner's scope of practice under state law.

Covered Services:
The Program shall cover evidence-based, trauma-informed community violence prevention services rendered by certified violence prevention professionals to participants who have been exposed to community violence or received treatment for an injury sustained as a result of an act of community violence.

Covered services include: mentorship, conflict mediation, crisis intervention, referrals to certified or licensed health care professionals or social services providers, patient education, and screening services to victims of violence.

Qualified Provider Specifications:

1. A certified violence prevention professional shall be certified by Health Alliance for Violence Interventions or another certifying body as approved by the Department; such requirements must include at least thirty-five hours of initial training that address the following: (I) the effects and basics of trauma-informed care; (II) community violence prevention strategies, include conflict mediation and retaliation prevention related to community violence; (III) case management and advocacy practices; and, (IV) patient privacy and the federal Health Insurance Portability and Accountability Act of 1996; and at least six hours of continuing education every two years; and
2. The provider that renders community violence prevention services shall:
    a. Maintain an affiliation with at least one of the following institutions through which the provider entity is authorized to provide community violence prevention services to Medicaid members in the hospital.
        1. As determined by MIEMMS, Maryland hospitals must have one of the following designations:
            a. Primary Care Resource Center (PARC)
            b. Level 1 Trauma Center
            c. Level II Trauma Center; or,
            d. Pediatric Trauma Center.
        2. Hospitals not located in Maryland Must have one of the following designations, as defined by the American College of Surgeons:

a. Level I Trauma Center;
b. Level II Trauma Center; or,
c. Pediatric Trauma Center.

b. Maintain documentation that the certified violence prevention professionals rendering services on their behalf have met the requirements of this section; and
c. Ensure that the VP(s) are providing community violence prevention services in compliance with any applicable standard of care, rule, regulation, and state or federal law.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan. d. Rehabilitation Services VIII. Therapeutic Behavioral Services	A. Therapeutic behavioral services are intensive, rehabilitative services, for individuals under 21 years of age and are intended to: (1) Provide the recipient with behavioral management skills to effectively manage the behaviors or symptoms that place the recipient at risk for a higher level of care; and (2) Restore the recipient's previously acquired behavior skills and enable the recipient to develop appropriate behavior management skills. B. Therapeutic behavioral services must be: (1) Diagnosed, identified, and prescribed by a provider to be medically necessary; (2) Recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law; (3) Preauthorized by the Department or its designee; and (4) Delivered in accordance with the behavioral plan developed as part of a therapeutic behavioral assessment. C. The following therapeutic behavioral services are covered: (1) Therapeutic behavioral assessment that includes the development of a behavioral plan; and (2) One-to-one intervention for a specified period of time at the appropriate site in accordance with the behavioral plan; and may include, but are not limited to: a. Assisting the recipient to engage in or remain engaged in appropriate activities; b. Minimizing the recipient's impulsive behavior; c. Providing immediate behavioral reinforcements; and d. Collaborating with and supporting parent and guardian.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan. d. Rehabilitation Services VIII. Therapeutic Behavioral Services	D. Therapeutic behavioral service providers shall be one of the following organizations: (1) A Developmental Disabilities Administration (DDA) provider that has been licensed by DDA to provide services to individuals with developmental disabilities that must: a. Have a governing body that is legally responsible for overseeing the management and operation of all programs; b. Be in compliance with all applicable laws and regulations; and c. Have a business plan, a written quality assurance plan, and positive licensing history. (2) An outpatient mental health clinic that has been licensed by the Office of Health Care Quality, and has: a. A program director who is a licensed mental health professional, or has a master's level professional degree; b. A medical director who is a psychiatrist; and c. A multidisciplinary licensed mental health professional staff of two different mental health professions. (3) A Mobile Treatment Service (MTS) program that has been licensed by the Office of Health Care Quality and has: a. A program director who is a mental health professional; b. A psychiatrist; c. A registered nurse who is licensed under the provisions of Health Occupations Article, Title 8, Annotated Code of Maryland, and

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan. d. Rehabilitation Services VIII. Therapeutic Behavioral Services	d. A social worker who is licensed under the provisions of Health Occupations Article, Title 19, Annotated Code of Maryland. (4) Psychiatric Rehabilitation Program (PRP) that has been licensed by the Office of Health Care Quality and has: a. A program director who has sufficient qualifications, knowledge, and experience to execute the duties of the position and has a minimum of 3 years experience working with emotionally disturbed youth; and b. A licensed mental health professional with 2 years direct care experience working with emotionally disturbed youth. (5) School Providers that have been recognized by Maryland State Department of Education and approved by the U.S Department of Education to participate in the IDEA program E. The therapeutic behavioral service provider must: (1) Ensure that therapeutic behavioral aides are trained and supervised; (2) Ensure that a written progress note is completed for each time period that a therapeutic behavioral aide spends with the recipient. The note must describe: a. The location, date, end and start time of the service; b. A brief description of the service provided; c. A brief description of the recipient's behaviors or symptoms; and

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan. d. Rehabilitation Services VIII. Therapeutic Behavioral Services	d. The signature of the behavioral aide. F. The therapeutic behavioral assessment itself and the development of the behavioral plan of care must be performed by a licensed or certified health care professional that is employed by one of the organizations described in D above. These providers do not require supervision and include: (1) Licensed Certified Professional Counselor with a Doctoral degree with a minimum of 2 years professional supervised experience or with a master's degree with 3 years of professional supervised experience. (2) Licensed Clinical Marriage and Family Therapist with a Doctoral degree in marriage and family therapy with a minimum of 2 years professional supervised experience. (3) Licensed Certified Social Worker-Clinical with a Masters degree with a minimum of 2 years professional supervised experience. 4) Certified Registered Nurse Practitioner with an advanced practice Degree from a nursing education program. 5) Advanced Practice Registered Nurse/Psychiatric Mental Health which is a Registered nurse with a master's degree or higher. (6) Licensed Psychologist with a Doctoral degree in psychology with 2 years of professional supervised experience. (7) Physician with a Doctor of medicine degree or a Doctor of osteopathy degree.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan. d. Rehabilitation Services VIII. Therapeutic Behavioral Services	G. Therapeutic behavioral service aides employed by a provider described in D above must be: (1) Available on-site to provide one-to-one behavioral assistance and intervention to accomplish outcomes specified in the behavioral plan. (2) Health care professionals or nonprofessionals who are supervised by an individual who is licensed, certified, or otherwise legally authorized to provide mental health services independently in the state where the service is rendered. The TBS plan specifies the frequency of review by the licensed practitioner, and must document the date and time of service, activities, changes in behavior plan as a result of intervention, and signed by the aide and supervisor weekly and supervised by a health care professional mentioned in F above. These include: a. Social Work Associate with a Bachelor's degree in social work, licensed by the Office of Health Care Quality, and supervised by a licensed certified social worker. b. Rehabilitation Specialist with a bachelor's degree with a minimum of 2 years direct care experience working with emotionally disturbed youth and 60 hours of supervision by a psychiatric rehabilitation practitioner. licensed mental health professional. c. Rehabilitation counselor who is currently certified by the Commission on Rehabilitation Counselor Certification and supervised by a health care professional mentioned in F above.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan. d. Rehabilitation Services VIII. Therapeutic Behavioral Services	d. Certified psychiatric rehabilitation practitioner currently certified by the U.S. Psychiatric Rehabilitation Association and supervised by a health care professional mentioned in F above. e. Psychiatric Rehabilitation direct care staff must have a high school equivalent with 40 hours of PRP training and supervised by a health care professional mentioned in F above. f. TBS aide must: (i) Have a high school equivalent and Administration approved training; (ii) Receive appropriate training and documentation of such must be maintained that includes the course study, date, course outline and qualified instructor. H. Limitations (1) To be eligible for therapeutic behavioral services the: a. Recipient shall be younger than 21 years old; b. Recipient shall be assessed as having behaviors or symptoms related to a mental health diagnosis that places the individual's current living arrangement at risk and creates a risk for a more restrictive placement, or prevents transition to a less restrictive placement; c. Recipient's behaviors or symptoms shall be safely and effectively treated in the community; and

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan. d. Rehabilitation Services VIII. Therapeutic Behavioral Services	d. Recipient's parent, guardian, or individual who customarily provides care shall be present. during the provision of all therapeutic behavioral services to participate in the behavioral plan, unless there are clinical goals specifically addressed in the behavior plan that need to be achieved requiring that the parent, guardian, or individual who customarily provides care not be present. (2) Therapeutic behavioral services shall be limited to services that meet the federal definition of rehabilitation services. (3) Therapeutic behavioral services provided by school health-related services providers that are not included on a child's IEP or IFSP are not covered by the Program. 1. Preauthorization (1) Providers must obtain preauthorization from the Department or its designee for all services for which a claim is to be submitted with the exception of IEP/IFSP services where the authorization for the service is contained within the IEP/IFSP. (2) The initial authorization shall be given for not more than 60 calendar days. (3) Additional authorization beyond the initial authorization shall be requested at a minimum, every 60 days and in advance of the expiration of the previous authorization. (4) Authorization may only be given if the therapeutic behavioral service continues to be effective and progress towards the specified goals is documented.

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PROGRAM	LIMITATIONS
13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan. d. Rehabilitation Services VIII. Therapeutic Behavioral Services	(5) If it is determined that TBS are no longer having a restorative impact on the recipient, the recipient will be clinically reassessed and if determined to need other State Plan services, the recipient will be transitioned to the State Plan services appropriate to his/her needs.

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

d. Rehabilitation Services

IX. Behavioral Health Crisis Services

I. Mobile Crisis Team Service

Mobile crisis team (MCT) service is the provision of professional, same-day intervention for children or adults who are experiencing behavioral health crises. Mobile crisis is available 24 hours per day, seven days per week and must be culturally, linguistically, and developmentally appropriate. This service is provided to a beneficiary in the community, outside of a hospital or other facility setting.

A. Service Description:
Mobile crisis team (MCT) services shall involve:
   a. A timely in-person response by a multidisciplinary team of at least two team members who must respond in person;
   b. An initial assessment by a mental health professional described in B(a) below, which may be performed via telehealth as long as two other team members respond in person;
   c. Crisis intervention and stabilization of the individual's behavioral health crisis;
   d. Safety planning;
   e. Referrals to community supports, including behavioral health providers, health providers, or social and other services as needed; and
   f. Mobile crisis follow-up outreach by means of telephone, telehealth, or in-person contact with the individual served or family member and referred providers, if applicable.

B. Provider Qualifications:
   a. MCT providers must ensure that the team composition includes at least one licensed mental health professional (LMHP) responding in person or via telehealth. LMHPs are authorized by State law to complete assessments and include practitioners defined in Attachment 3.1-A page 19-6.g. of the State Plan, and appropriately supervised licensed graduate level social workers and licensed graduate professional counselors.
   b. The team may also include:
      i. A certified peer recovery specialist or certified family peer specialist as certified by the Behavioral Health Administration or its designated entity;
      ii. Other professionals who are licensed or certified by the State Health Professional Licensing Boards or relevant national certification boards to practice in the state and have completed the required training requirements as described in (d) below; or
      iii. Other paraprofessionals age 18 years or older with relevant experience in behavioral health or a related field and who complete the training requirements as described in (d) below.
   c. MCT providers must be licensed by the designated state licensing agency to provide mobile crisis team services;

d. Agencies providing MCT services must ensure all staff receive appropriate supervision and have training as approved by the Department in the areas of crisis intervention, de-escalation, trauma-informed care, and harm reduction; and
e. Agencies providing MCT services must operate and be available to respond 24 hours a day, 7 days per week.

II. Behavioral Health Crisis Stabilization Center Service

Behavioral health crisis stabilization center (BHCSC) service is the provision of short-term crisis intervention and stabilization for individuals in a facility open 24 hours, seven days a week and staffed to manage the full array of behavioral health emergencies including alcohol and substance abuse, symptoms of mental illness, and emotional distress. This service is intended to provide the least restrictive environment for individuals at risk for emergency department visits, hospitalization, and incarceration.

A. Service Description:
Behavioral health crisis stabilization center (BHCSC) services are available on a short-term basis for less than 24 hours and shall involve:
a. An initial assessment by a registered nurse;
b. An assessment completed by a licensed mental health professional;
c. An initial evaluation by an approved physician or psychiatric nurse practitioner;
d. Crisis intervention and stabilization of the individual's behavioral health crisis by a licensed mental health professional, physician, or certified peer recovery specialist or certified family peer specialist;
e. Safety planning by a licensed mental health professional or certified peer recovery specialist or certified family peer specialist;
f. Medication management and harm reduction as needed, including but not limited to naloxone and buprenorphine, by a physician, nurse practitioner, psychiatric nurse practitioner, or physician assistant; and
g. Care-coordination with and referrals to community-based services or higher levels of care as clinically indicated by a licensed mental health professional, certified peer recovery specialist or certified family peer specialist, or other licensed professional or paraprofessional as described in B.(a) below.

B. Provider Qualifications:
a. Eligible practitioners for this service include:
i. Registered nurses licensed by the Maryland Board of Nursing:
ii. Physicians licensed by the Maryland Board of Physicians;
iii. Certified peer recovery specialists or certified family peer specialists as certified by the Behavioral Health Administration or its designated entity:
iv. LMHPs as described in I.B(a) above;
v. Nurse practitioners as licensed by the Maryland Board of Nursing;
vi. Physician assistants licensed by the Maryland Board of Physicians;
vii. Other professionals who are licensed or certified by the State Health Professional Licensing Boards or relevant national certification boards to practice in the state and have completed the required training requirements as described in (c) below; and

viii. Other paraprofessionals age 18 years or older with relevant experience in behavioral health or a related field and who complete the training requirements in (c) below.

b. Providers must be licensed by the designated state licensing agency to render BHCSC services;
c. Agencies providing BHCSC services must be open and available 24 hours a day, 7 days per week;
d. Agencies must ensure staff complete training requirements as directed by the Department;
e. Providers must ensure staff operate within their scope of practice pursuant to State law; and
f. Providers must ensure staff receive appropriate supervision as required by State law.

14. Services for individuals age 65 or older in institutions for mental diseases

    a. Inpatient Hospital Services

    b. Nursing Facility Services

    These services are covered under 4.a Nursing Facility services with the exception of the following Limitation:

    The Department or its designee shall certify the recipient as requiring nursing facility services for individuals age 65 or older in institutions for mental diseases.

15. Intermediate Care Facilities Services for the intellectually disabled or persons with related conditions

The Department or its designee will certify the recipient as requiring intermediate care facility services for the intellectually disabled or persons with related conditions.

16. Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities

Billing time limitations apply as described in 4.19A

Reserve for Future Use

Reserve for Future Use

STATE PLAN FOR MEDICAL ASSISTANCE
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18. Description of Services: HOSPICE CARE SERVICES

Hospice care services are provided to recipients who are terminally ill and who voluntarily elect hospice care. Services include those that are reasonable and necessary for the palliation or management of the recipient's terminal illness and related conditions. Hospice services provided to recipients under 21 years of age must be made available without forgoing any other services to which the recipient is entitled under Medicaid for treatment of the terminal illness.

Provider Types:

Employees of the hospice who provide hospice care services must be licensed, certified, or registered in accordance with applicable federal, State, and local laws. Providers of hospice services must also be enrolled as a Medicare hospice provider.

Limitations

- Hospice care shall be available to an individual for an initial 90-day period, a subsequent 90-day period, and an unlimited number of subsequent 60-day periods, after the first 2 election periods are utilized.
- A written certification of terminal illness shall be obtained by the hospice for each election period, documenting the prognosis of a life expectancy of 6 months or less.
- A face-to-face encounter shall occur between the recipient and the certifying physician for certification of the terminal illness, no more than 30 days prior to the third election period and any subsequent election periods.
- Any election period shall be terminated before expiration when a participant dies, revokes hospice care, is no longer eligible for Medical Assistance, or is no longer certified as terminally ill.
- A participant may designate a new provider of hospice care no more than once during an election period.
- When a participant is enrolled in Medicare Part A, Program payment for hospice care shall be limited to payment of the Medicare hospice care coinsurance amounts for drugs and biologicals and for respite care and, where applicable, room and board for residents of a nursing facility.

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PROGRAM	LIMITATIONS
20. a. Pregnancy-related and postpartum services for 60 days after pregnancy ends.	Any covered medicaid service that is required during the 60 days after pregnancy ends, that is pregnancy-related or postpartum-related, will be provided.
b. Services for any other medical conditions that may complicate pregnancy	Any covered medicaid service that is required for medical conditions that may complicate pregnancy will be provided.

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23. Any other medical care type of remedial care recognized by the Secretary

A. Transportation

See Attachment 3.1D for description of Non-Emergency Transportation Services and assurances.

1. Emergency Service Transporters

Services provided by an ambulance provider under the Medicaid program must be demonstrated to be medically necessary and are subject to limitations described herein. Medical necessity is indicated when the patient's condition is such that any other means of transportation would endanger the patient's health.

Ambulance transportation is not considered medically necessary when any other means of transportation can be safely utilized.

Emergency ambulance transportation may be used for the client to receive immediate and prompt medical services arising in an emergency situation. Emergency transportation to a physician's office is covered only if all the following conditions are met:

- The patient is en-route to a hospital.
- There is medical need for a professional to stabilize the patient's condition.
- The ambulance continues the trip to the hospital immediately after stabilization.

Under this chapter, the Program does not cover services:

a. Unless in response to a "911" call;
b. Performed by an emergency service transporter that is not enrolled with the Program;
c. To anyone other than an eligible recipient; and
d. For which proper documentation, including but not limited to run sheets, cannot be provided on request of the Department or its designee.

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STATE OF MARYLAND

2. Transportation Services under the Individuals with Disabilities Education Act (IDEA)

   a. Only providers who are local education agencies, local lead agencies, state-operated education agencies, or state-supported education agencies may participate.

   b. Providers shall only bill the program for transportation service on dates when another Medicaid covered service(s) is provided and both the Medicaid covered service and Transportation service are documented. Both the Medicaid covered service and specialized Transportation must be identified on the IEP or IFSP.

   c. The transportation must be identified as "specialized" transportation. That means that the transportation is not the same as transportation for a child's non-disabled peers. For example, a bus aide, specialized equipment or specialized training for the bus driver, a stop in front of the child's house, change of route for child, or transportation to a school that is not the child's local school, e.g. a nonpublic school or special school for children with disabilities, will be specialized transportation. The bus can be a regular school bus if it is specialized to meet the needs of the child.

   d. Transportation is provided to and from a school where a Medicaid-covered IDEA service is provided. Transportation to or from a site where a Medicaid Early Intervention service is provided; and between a school and a Medicaid covered service and home or return to the school.

Reserve for Future Use

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

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Services that require preauthorization
23. f. Personal Assistance services in a participant's home or community

Personal Assistance services are covered when preauthorized in a plan of service on an assessment of need. Personal Assistance Services also include:

1) Supports planning and
2) Nurse monitoring.

To participate in the Program, the personal assistance provider shall:

1) Comply with applicable federal and State laws, regulations, transmittals, and guidelines; and
2) Record time in accordance with procedures outlined in the Department's policies and procedures.
3) Be licensed as a residential services agency.

Supports planning services coordinate services and develop the plan of service. To participate in the Program as a supports planning provider, a provider shall be:

1) Identified by the Department through a solicitation process and agree to be monitored by the Department; or
2) The area agency on aging.

Nurse monitoring services provided by a registered nurse who completes nursing assessments on participants and evaluates the delivery of personal assistance services. To participate in the program as a provider of nurse monitoring, a provider shall be enrolled with Community First Choice.

LIMITATIONS

The following services are not covered:

1) Skilled nursing;
2) Services primarily for the purpose of housekeeping;
3) Meals delivered to the home;
4) Expenses incurred by providers while escorting participants to obtain medical diagnosis or treatment; and
5) Travel time;
6) Nurse monitoring services in the absence of personal assistance service.

Reserve for Future Use

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

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23.h. Nurse Practitioner Services

This section includes certified pediatric and certified family nurse practitioners. Both groups must meet requirements listed under 440.166 of the Code of Federal Regulations. See section 6e of this plan for limitations for other licensed nurse practitioners.

The Program reimburses pediatric and family nurse practitioners directly for medically necessary services rendered to recipients in accordance with the functions allowed under the Maryland Nurse Practice Act or COMAR 10.27.07 and the certified nurse practitioner's written agreement with a physician or, if out of state, those functions authorized in the state in which the services are provided. These services shall be clearly related to the recipient's medical needs and described in the recipient's medical record in sufficient detail to support the invoice submitted for those services. A certified pediatric or family nurse practitioner may practice in Maryland only in the area of specialization in which the nurse practitioner is certified by the Nursing Board; or, if out of state, only in the area of specialization allowed by the licensing authority in the state in which services are provided.

A. Services which are not covered are:

1. Services not encompassed by the certified nurse practitioner's written agreement with the physician, if required by the state in which services are provided;

2. Services not medically necessary;

3. Services prohibited by the Maryland Nurse Practice Act or by COMAR 10.27.07;

4. Services prohibited in the state in which services are provided;

5. Nurse practitioner services included as part of the cost of an inpatient facility, hospital outpatient department, or freestanding clinic;

6. Visit solely to accomplish one or more of the following:
   a. Prescription, drug or food supplement pick-up, collection of specimens for laboratory procedures;
   b. Recording of an electrocardiogram;
   c. Ascertaining the patient's weight;
   d. Interpretation of laboratory tests or panels which are considered to be part of the office visit and may not be billed separately;

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7. Drugs and supplies dispensed by the nurse practitioner which are acquired at no cost;

8. Payment to nurse practitioners for specimen collection, except by venipuncture and capillary or arterial puncture;

9. Injections and visits solely for the administration of injections, unless medical necessity and the patient's inability to take appropriate oral medications are documented in the patient's medical record;

10. Services paid under COMAR 10.09.22, Free-Standing Dialysis Facility Services;

11. More than one visit per day unless adequately documented as an emergency situation;

12. Audiometric tests for adults for the sole purpose of prescribing hearing aids since hearing aids are not covered for adults;

13. Immunizations required for travel outside the continental United States;

14. Services which are investigational or experimental;

15. Services which are provided outside of the United States.

RESERVE FOR FUTURE USE

RESERVE FOR FUTURE USE

State of Maryland
PACE State Plan Amendment

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State/Territory:
Maryland

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: ___X____

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X_Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X_A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X_A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Supplements to Attachment 3.1-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

CASE MANAGEMENT SERVICES

A. Target Group: Persons who are certified for and are receiving Medical Assistance benefits, who do not reside in long-term care institutions, for whom case management has been recommended in the plan of care developed as part of the STEPS multidisciplinary assessment as necessary to enable the individual to gain access to services, who choose to receive STEPS case management services, who are not receiving the same case management services under a Section 1915(b) or (c) waiver, and who are not hospital inpatients.

B. Areas of State in Which Services Will Be Provided:

☒ Entire State

☐ Only in the following geographic areas (authority of 1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

☐ Services are provided in accordance with 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration and scope. Authority of 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of 1902(a)(10)(B).

D. Definition of Services:

(See attached pages 2 - 3).

E. Qualifications of Providers:

(See attached pages 3-4).

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

D. Definition of Services:

1. Case Management means a service which will assist participants in gaining access to:
   a. The full range of Medical Assistance services for which the individual is qualified and
   b. Any other needed support services such as medical, social, housing, financial, adult day care, in-home aide, and counseling.
2. In the 60-day period immediately following the Statewide Evaluation and Planning Services (STEPS) multidisciplinary assessment, initial STEPS case management includes, as a unit of service, the initial encounter with the participant to establish a plan of care, as well as all other covered services necessary for implementation of the plan of care. After this initial 60-day period, ongoing case management activities include, as a unit of service,a monthly telephone contact with the participant and all other covered services necessary as part of the follow-up.
3. The Department reimburses for case management services which include:
   a. Discussing with the participant the recommended plan of care from the STEPS multidisciplinary assessment and informing the participant of the availability of the recommended services for which the participant is potentially eligible;
   b. Arranging for delivery of services by referring the participant to qualified providers and negotiating with and securing service providers selected by the participant;
   c. Following up promptly to ensure that all services are in place and that the quantity and quality are sufficient to meet the participant's needs;
   d. Monitoring the participant and the service provision on an ongoing basis. This activity includes regular telephone contact with the recipient, recipient's family or significant others, and service providers. The telephone contacts should occur as often as necessary, but at least monthly. It also includes regularly scheduled home or in-person visits, at least quarterly.
   e. Providing assistance to service providers. This activity includes providing patient-specific information to service providers, with the participant's written consent, in order to help them provide appropriate care.

f. Determining the participant's desire and continuing need for case management services, to enable the participant to remain in the community. This determination is made no later than 60 days after case management begins and at least every 6 months after the initial 60 days. As necessary, the plan of care is revised with the participant's input. If the participant's condition changes significantly, he/she is referred for a STEPS reassessment.

4. The following conditions must be met for services to be reimbursed:
   a. Case management was recommended in the STEPS plan of care as necessary to enable the individual to remain in the community, and the participant chooses to receive such services;
   b. The STEPS case management provider and case manager are available to provide case management services not more than 3 working days after the receipt of the STEPS multidisciplinary assessment's plan of care recommendations and selection by the participant as the provider and case manager;
   c. The services are rendered to qualified participants for STEPS case management;
   d. The STEPS case management services are adequately performed as reflected on the completed form specified by the Department and submitted to the Program as a condition for payment; and
   e. The services are rendered by a provider approved to perform STEPS case management.

E. Qualifications of Providers

1. A provider of STEPS case management services must be a health services agency:
   a. Providing STEPS case management through an appropriate agreement with the Department and identified as a Program provider by the issuance of an individual account number;
   b. Employing licensed registered nurses and licensed social workers as case managers. The licensed registered nurses must:
      (i) Have 2 years of community health nursing experience; or
      (ii) Be directly supervised by a licensed registered nurse with 2 years of community health nursing experience; and

c. Demonstrating experience in providing case management services and in implementing plans of care for aged and chronically ill clients.

2. In order to be reimbursed by the State, a provider of STEPS case management services must:

a. Ensure that employees performing STEPS case management meet the licensure requirements for either a nurse or social worker pursuant to the relevant Health Occupations Article in the Annotated Code of Maryland;
b. Apply for participation in the Program using the application form designated by the Department;
c. Be approved for participation by the Department;
d. Have a provider agreement in effect;
e. Verify the licenses and credentials of all professionals who are employed by, or who contract with, the provider of services;
f. Verify the eligibility of recipients, as part of the billing process;
g. Accept payment by the program as payment in full for services rendered and make no additional charge to any person for STEPS case management;
h. Provide services without discrimination on the basis of race, color, age, sex, national origin, marital status, physical or mental handicap;
i. Place no restrictions on a recipient's right to select among available health care providers;
j. Maintain adequate records for a minimum of 5 years, and make them available, upon request, to the Department or its designee;
k. Not knowingly employ or contract with person, partnership, or corporation which has been disqualified from the Program to provide or supply service to Medical Assistance recipients, unless prior written approval has been received from the Department;
l. Agree that claims rejected for payment due to late billing may not be billed to the participant;
m. Have a written plan for the implementation of STEPS case management;
n. Be available to participants at least 8 hours a day, 5 days a week, have established hours of daily operation, including after hours procedures for handling emergency cases.
o. Have existing policies and procedures concerning the provision of STEPS case management services;

p. Develop, as appropriate, interagency, intra-agency, and other agreements in order to facilitate access to long-term care services and coordinate with local public agencies and other providers of long-term care; and

q. Provide case management services to STEPS participants.

REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES
Supplement 1-A to Attachment 3.1-A (Page 1)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

CASE MANAGEMENT SERVICES
FOR HIV-Infected Individuals

A. Target Group:

A participant is eligible for HIV case management services if the participant is certified for and enrolled in the Maryland's Medical Assistance Program, diagnosed as HIV-(human immunodeficiency virus) infected, or is a child less than 2 years old born to a woman diagnosed as HIV-infected. HIV infection would be determined by the enzyme-linked immunosorbent assay (ELISA) and confirmed by the Western Blot, or another generally accepted diagnostic testing algorithm for HIV infection. Participation is conditional on the recipient's election of HIV targeted case management and on comparable case management services not being reimbursed under another Program authority. The target group does not include any individual who is an inmate of a public institution or those recipients currently residing in, or transitioning from or to, an institution.

B. Areas of State in which Services will be provided (§1915(g)(1) of the Act):

X Entire State
___ Only in the following geographic areas: [Specify areas:]

C. Comparability of Services (§1902(a)(10)(B) and §1915(g)(1)):
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount, duration and scope (§1915(g)(1)).

D. Definition of Services:

1. Case management means services which will assist participants in gaining access to the full range of Medical Assistance services, as well as to any additional needed medical, social, housing, financial, counseling, and other support services.

2. The Maryland Medical Assistance Program covers the following HIV targeted case management services when they have been documented as appropriate and necessary:

   a) HIV diagnostic evaluation services (DES) which include, as a unit of service, performance of a bio-psychosocial assessment and the development or revision of an individualized plan of care; and

b) HIV ongoing case management services which include the activities involved in implementing and monitoring the plan of care, as performed by a nurse, social worker or physician.

3. Targeted Case Management is a continuum of services that ensures a rapport between the recipient and case manager and develops and implements a person-centered plan. Diagnostic evaluation services (DES) are completed to evaluate and set goals for each recipient and ongoing case management helps the recipient realize those goals.

   DES includes the completion of a comprehensive bio-psychosocial assessment of a participant and the development or revision of a participant's individualized plan of care on an initial and annual basis, unless an earlier assessment is recommended by the case manager or multidisciplinary team. A multidisciplinary team develops and completes the bio-psychosocial assessment and plan of care.

   a) Bio-psychosocial assessment includes gathering information from various sources (e.g., family members, medical providers, etc.) and a face-to-face assessment of the participant, preferably at the participant's residence, to determine
      - i) Medical/psychiatric/substance abuse history (including current medications);
      - ii) Nutritional status;
      - iii) Emotional/behavioral status;
      - iv) Health care coverage;
      - v) Living situation;
      - vi) Personal support systems;
      - vii) Employment/income status;
      - viii) Health education;
      - ix) Social support;
      - x) The participant's level of need (the team is required to document the frequency of contact, with a minimum requirement of one face-to-face contact every six months); and
      - xi) Any additional service needs.

   b) After the bio-psychosocial assessment is completed, an individualized plan of care is developed. The plan of care:
      - i) Is person-centered and includes specific, measurable, achievable, realistic and time-framed goals;
      - ii) Is developed and written in collaboration with the participant and other members of the multidisciplinary team; and
      - iii) Incorporates findings and recommendations from the multidisciplinary team.

Ongoing case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. Ongoing case management activities include implementing and monitoring the plan of care through an approved HIV ongoing case management provider agency.

a) Ongoing case management services are provided to participants based on the plan of care and shall include:
   i) Regular contact that occurs at intervals agreed upon in the plan of care by the participant and case manager;
   ii) Response to participant-initiated non-emergency contact within two working days;
   iii) Documentation of every direct and indirect contact, including assessing the progress of implementation of the plan of care in the participant's record.
   iv) Assistance to the participant with each action plan to reach the goals outlined in the plan of care;
   v) Follow up by the case manager with providers in which the recipient has been referred for services; and
   vi) Examination of the actual service delivery against the plan of care.

b) Ongoing case management includes monitoring and evaluating at least every six months, with input from any members of a multidisciplinary team who have been involved with the participant's plan of care:
   i) If activities outlined in the plan of care are both furnished and adequate; and
   ii) If the needs of the participant have changed. If applicable, ongoing case management may include making necessary adjustments to the care plan including referrals for services.

c) The case manager will document a participant's case closure including:
   i) Participant notification, including date of closure, reason and/or explanation of closure;
   ii) Participant's notification of right to re-enter services at a later time;
   iii) Documentation of coordination and referral to a new provider as desired by the participant; and
   iv) Documentation of a participant's non-response to case manager attempts to reach the participant over a six-month period of time with at least three attempts to contact the participant.

E. Qualifications of Providers:

1. General requirements for participation in the Program are that providers shall be enrolled as a Medicaid provider and maintain a record on each participant.

2. Specific requirements for participation as a DES provider include all of the following:

   a) Be a physician or a health or social services entity which employs or has a written agreement with physicians, nurses or social workers, who are currently licensed in the State of Maryland, for provision of its diagnostic evaluation services who are experienced or trained in the provision of services to HIV-infected individuals.

   b) Have a written plan for the implementation of HIV diagnostic evaluation services.

   c) Be available to participants at least 8 hours a day, 5 days a week, except on State holidays.

   d) Have existing policies and procedures concerning the performance of HIV diagnostic evaluation services.

   e) Develop procedures to expedite bio-psychosocial assessments when necessary.

   f) Have access to specialty physicians experienced and trained in provision of services to HIV-infected individuals, for consultation as necessary concerning a participant's medical assessment and the medical services recommended in the plan of care.

   g) Present a qualified recipient with the option of receiving HIV diagnostic evaluation services and HIV ongoing case management services. The participant shall select a qualified ongoing case management provider.

   h) Establish a written agreement with any entity approved as an HIV ongoing case management provider which a participant selects as his or her ongoing case manager and agrees to allow the case manager chosen by the participant to:
      i) Participate as a member of the multidisciplinary team;
      ii) Assist with performance of the bio-psychosocial assessment;
      iii) Assist with the development and revision of the plan of care; and
      iv) Monitor the participants need for a revised bio-psychosocial assessment.

i) Convene a multidisciplinary team for each participant to perform the bio-psychosocial assessment and develop or revise an individualized plan of care. The team shall be composed of:
   i) The participant (and the participant's legally authorized representative if applicable);
   ii) Representative(s) chosen by the participant, if desired. A representative from the DES provider which may include any of the following as necessary and appropriate: the participant's primary care physician, nurse, current service provider(s), specialty physician, or social worker; and
   iii) The participant's ongoing case manager. If employed by the DES provider, the ongoing case manager may act as the representative from the DES provider.

j) Inform the participant and the participant's legally authorized representative(s) of recommendations for the plan of care identified from the bio-psychosocial assessment and the availability of needed services.

k) Have the capacity to conduct, at minimum, an annual bio-psychosocial assessment of the participant, unless an earlier assessment is recommended by the case manager or multidisciplinary team.

3. Specific requirements for participation as an ongoing case management provider include all of the following:

a) Be a health or social services entity employing registered nurses, licensed social workers, or licensed physicians who are trained and have at least one year experience in the provision of services as a case manager. Experience may have been acquired as volunteer work or field placement.

b) Have a written agreement:
   i) With any entity approved as an HIV diagnostic evaluation services provider from whom the ongoing case management provider is accepting referrals; and
   ii) Which permits the case manager to participate as a member of the multidisciplinary team, to have access to the plan of care, to request status updates and reports from medical providers, and to request a bio-psychosocial assessment and plan of care revision as necessary.

c) Have a written plan for the implementation of HIV ongoing case management services.

d) Have existing policies and procedures concerning the performance of HIV ongoing case management.

e) Provide ongoing case management services to participants.

f) Be available to participants at least 8 hours a day, 5 days a week, except on State holidays.

g) Have established alternatives for managing participants' medical and social crises during off-hours that will be specified in participants' individualized plans of care.

h) Have the capacity to meet with the participant face-to-face.

i) Be knowledgeable of the eligibility requirements and application procedures of applicable federal, State, and local government assistance programs.

j) Maintain a current listing of medical, social, housing assistance, mental health, financial assistance, counseling, and other support services available to HIV-infected individuals.

4. The specific requirement for participation in the Program as a provider of services covered under this chapter is that all providers must maintain a record on each participant which meets the Program's requirements and which includes:
   a) Verification of the participant's HIV-infected status.

   b) Verification of the participant's eligibility for services.

   c) A signed consent form by the participant to participate in ongoing case management.

   d) The completed bio-psychosocial assessment.

   e) The completed plan of care signed by all members of the multidisciplinary team.

   f) Documentation for each contact made by the case manager including:
      i) Date and subject of contact;
      ii) Person contacted;
      iii) Person making the contact;
      iv) Nature, extent, and unit or units of service provided; and
      v) Place of service.

   g) A signed case closure form when ongoing case management services are ended.

F. Freedom of Choice:

The State assures that the provisions of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Access to Services:

The state assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.

2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

4. The State assures that the amount, duration, and scope of the case management activities would be documented in a participant's plan of care.

H. Payment

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Case Records:

Providers maintain medical records that document the following for all participants receiving case management:

1. The name and Medicaid identification number of the participant.
2. Dates of the case management services.
3. The name of the provider agency (if relevant) and the person providing the case management service.
4. The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.
5. Whether the participant has declined services in the care plan.
6. The need for, and occurrences of, coordination with other case managers.
7. The timeline for obtaining needed services.
8. A timeline for reevaluation of the plan.

J. Limitations:

1. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
2. Case Management does not include, and FFP is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements, recruiting or interviewing potential foster care parents; serving legal papers, home investigation, providing transportation; administering foster care subsidies; making placement arrangements.
3. FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

Reserve for future use

Reserve for future use

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State Plan under Title XIX of the Social Security Act
State/Territory: Maryland

TARGETED CASE MANAGEMENT SERVICES:
Individuals with Serious Mental Health Disorders

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

A beneficiary is eligible for mental health case management services if the beneficiary:

1) Adults, age 18 and over, who have a serious mental health disorder, diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Department, and who:

   a) Are at risk of or need continued community treatment, to prevent inpatient psychiatric treatment;

   b) Are elderly individuals, or young adults ages 18 through 21 who have been discharged from inpatient treatment in an Institution for Mental Disease;

   c) Are at risk of, or need continued community treatment to prevent being homeless; or

   d) Are at risk of incarceration or recently released from a detention center or prison.

2) All participants must meet at least one of the following conditions:

   a) The participant is not linked to mental health and medical services;

   b) The participant lacks basic supports for shelter, food, and income;

   c) The participant is transitioning from on level of care to another level of care; or

   d) The participant needs case management services to maintain community-based treatment and services.

3) The Department or its designee will authorize service delivery level based on the participants' needs.

_X_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to **30** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

B. Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State

State Plan under Title XIX of the Social Security Act
State/Territory: Maryland

TARGETED CASE MANAGEMENT SERVICES:
Individuals with Serious Mental Health Disorders

___ Only in the following geographic areas:

C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

D. Definition of Services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. The unit of service is one day, with a minimum of 1 hour per day of contact, which may include face-to-face contacts with a participant, and non-face-to-face contacts on behalf of the participant with nonparticipants, that are directly related to identifying the needs and supports for helping the individual to access services. The maximum service limit is 5 units per month, which may be exceeded based on clinical review by the Department or its designee. This includes all TCM activities, with the exception of the assessment, which uses a unit of service of one assessment and is billed separately.

Targeted Case Management includes the following assistance:

1) Comprehensive Assessment and Periodic Reassessment
   A community support specialist conducts a comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:

   a) Taking client history;
   b) Identification of the participant's stated needs and review of information concerning a participant's mental health, social, familial, cultural, medical, developmental, legal, vocational, and economic status to assist in the formulation of a care plan;
   c) Input from the participant, family members, and friends of the participant, as appropriate, and community service providers such as mental health providers, medical providers, social workers, and educators (if necessary) to form an assessment of the service needs of the participant;
   d) A required home visit by the community support specialist or community support specialist associate; and
   e) Reassessment to occur at least every six months.

2) Development (and Periodic Revision) of a Specific Care Plan
   a) Case management providers shall develop and periodically revise plans of care for each participant, based on the information collected through the assessment, that:

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i. Specifies the goals and actions to address the medical, mental health, social, educational, and other services needed by the individual;
ii. Includes activities such as ensuring the active participation and agreement of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
iii. Identifies a course of action to respond to the assessed goals and needs of the eligible individual.

b) The care plan shall be updated in conjunction with the participant's schedule for reassessments, to ensure that all services being provided remain sufficient. The participant, the participant's family, and any other significant others, with the participant's consent, shall participate with the community support specialist, to the extent practicable, in the development and regular updating of the participant's care plan.

c) The care planning process promotes consistent, coordinated, and timely service provision.

d) Care planning may include, as necessary and appropriate:
   i. The care planning meeting, which includes the participant and with the participant's consent, providers, family members, other interested persons, as appropriate, for the purpose of establishing, coordinating, revising, and reviewing the care plan;
   ii. The development and periodic updating of the written individualized care plan based on the participant's needs, progress, and stated goals; and
   iii. Transitional care planning that involves contact with the participant or the staff of a referring agency or a service provider who is responsible to plan for continuity of care from inpatient level of care or an out of home placement to another type of community service.

3) Referral and Related Activities.
   a) Community support specialist associates, under the direction of community support specialists, shall assure that the participant has applied for, has access to, and is receiving the necessary services. These services will be those that contribute to meeting the participant's needs and achieving goals as specified in the care plan, such as mental health, medical, social, or educational providers, resource procurement, transportation, or crisis intervention. This may include:
      i. Scheduling appointments for the participant to help the eligible individual obtain needed services;
      ii. Community support development by contacting, with the participant's consent, members of the participant's support network,

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including, family friends, and neighbors, as appropriate, to mobilize assistance for the participant;

iii. Crisis intervention by referral on an emergency basis when immediate intervention is necessary;
iv. Linking the participant to transportation to and from services;
v. Outreach in an attempt to locate service providers which can meet the participant's needs; and
vi. Reviewing the care plan with the participant and with the participant's consent, the participant's family and friends, as appropriate, in order to facilitate their participation in the care plan's implementation

4) Monitoring and Follow-up Activities:
   a) Monitoring and follow-up activities and contacts necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs. These activities may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one assessment every six months to determine whether the following conditions are met:
      i. Services are being furnished in accordance with the individual's care plan;
      ii. Services in the care plan are adequate; and
      iii. Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
   b) Engage in ongoing interaction with the participant, and, with the participant's consent, the participant's family and friends as appropriate and service providers.
   c) Follow up after service referral and monitor service provision on an ongoing basis, to ensure that the agreed-upon services are provided, are adequate in quantity and quality, and meet the participant's needs and stated goals; and
   d) Advocacy including:
      i. Empower the participant to secure needed services
      ii. Take any necessary actions to secure services on the participant's behalf; and
      iii. Encourage and facilitate the participant's informed decision making and choices leading to accomplishment of the participant's goals.
   e) The care plan may be revised to reflect changing needs identified from the service monitoring.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the

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eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
The local mental health authority, called core service agencies (CSA), are agents of the county government who are responsible for planning and coordinating mental health services at the local level. Case management providers currently under contract with a CSA shall be approved to provide case management services until the end of their existing contract. Thereafter, at least once every five years, CSAs shall develop request for proposals (RFP) for mental health case management programs with experience serving individuals with serious mental illness or emotional disorders through the public mental health system. Case Management services may be provided by local health departments unless the Director of the MHA and the county health officer determine that the provision of case management services would be preferable to be delivered by a private vendor

Qualified provider agencies of case management shall be: 1) approved or licensed in Maryland as a community mental health program under Mental Hygiene Administration's community mental health regulations or have three years experience providing mental health case management services, and 2) have at least 3 years experience providing services to individuals with serious mental illness A case management provider agency willing to furnish case management services to the target population submits an application to the Department in order to demonstrate compliance with case management regulations, including provider qualifications. The Department reviews the application, and, if warranted, approves the provider agency as a mental health case management program.

Before a participant receives case management services, the Department's Mental Hygiene Administration's (MHA) Administrative Services Organization (ASO) reviews the authorization request, determines if the participant is meets medical necessity criteria, and if the participant meets the criteria, the participant is authorized for case management services. The participant has the option to choose from a variety of case managers hired by the case management program.

1) General requirements for the participation in the Program are that a case management program shall be enrolled as a Medicaid provider and meet all the conditions for participation as set forth in the Code of Maryland Regulations (COMAR) regarding conditions for provider participation in the Maryland Medical Assistance Program.. These regulations describe the condition to participate in the Program, and that the provider shall comply and ensure compliance with all the Medical Assistance provisions listed in COMAR designated for their provider type.

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2) Specific requirements for participation in the Program as a mental health case management program include all of the following:

a) Place no restriction on the qualified participant's right to elect to or decline to:
   i. Receive mental health case management services as authorized by the Department or the Department's designee; or
   ii. Choose a community support specialist or associate as approved by the Department or the Department's designee.

b) Employ appropriately qualified individuals as community support specialists and community support specialist associates with relevant work experience, including experience with the population served by the program, including but not limited to Adults with serious and persistent mental disorders.

c) Assure that a participant's initial assessment shall be completed within 20 days after the participant has been authorized by the ASO and determined eligible for, and has elected to receive, mental health case management services. An initial care plan shall be completed within 10 days after completion of the initial assessment.

d) Maintain a file for each participant which includes all of the following:
   i. An initial referral and intake form with identifying information;
   ii. A written agreement for services signed by the participant or the participant's legally authorized representative and by the participant's community support specialist;
   iii. An assessment, documented according to the Administration's requirements;
   iv. A care plan, updated, at a minimum of every six months, which contains at a minimum:
      (1) A description of the participant's strengths and needs;
      (2) The diagnosis established as evidence of the participant's eligibility for services under this chapter;
      (3) The goals of the community support services, with expected target dates;
      (4) The proposed intervention;
      (5) Designation of the community support specialist with primary responsibility for implementation of the care plan; and
      (6) Signatures of the community support specialist, participant or the participant's legally authorized representative, and significant others if appropriate.
   v. An ongoing record of contacts made in the participant's behalf, which includes all of the following:
      (1) Date and subject of contact;
      (2) Individual contacted;
      (3) Signature of community support specialist or community support specialist associate making the contact;
      (4) Nature, content, and unit or units of service provided;
      (5) Place of service;

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(6) Whether goals specified in the care plan have been achieved; and
(7) The timeline for obtaining needed services.

vi. Monthly summary notes, which reflect progress made towards the participant's stated goals.

e) Have formal written policies and procedures, approved by the Department, which specifically address the provision of mental health case management services to participants in accordance with these requirements;

f) Be available to participants and, as appropriate, the participant's families for 24 hours a day, 7 days a week in order to refer participants to needed services and supports and in a psychiatric emergency, to refer to mental health treatment and evaluation services in order to prevent the participant from accessing a higher level of care;

g) Participants may decline case management services. This will be documented in the participant's case management record;

h) Designate specific qualified staff to provide mental health case management services that shall include at least on community support specialist per agency and also may include a community support specialist associate;

i. Community support specialist means an individual who is employed by the case management program to provide case management services to participants, is chosen as the case manager by the participant or the participant's legally authorized representative, and has at least a:
(1) Bachelor's degree in a mental health field and 1 year of mental health experience including mental health peer support, or
(2) Bachelor's degree in a field other than mental health and 2 years of mental health experience including a mental health peer support.

ii. Community support specialist associate means an individual who is employed by the case management program to assist community support specialists in the provision of mental health case management services to participants, work under the supervision of a community support specialist who delegates specific tasks to the associate, and has at least a high school degree or the equivalent, and 2 years of experience with individuals with mental illness including mental health peer support.

iii. Community support specialist supervisor means an individual who is employed or contracted to supervise case management services at

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a ratio of one supervisor for every eight community support specialists or associates; who provides clinical oversight of assessments and case management services rendered, and consultation and training to community support specialists and community support specialist associates regarding mental illness; who provides some direct case management services; and who is a mental health professional who is authorized and licensed under Maryland Practice Boards in the profession of Social Work, Professional Counseling, Psychology, Nursing, Occupational Therapy, or Medicine; and has one year experience in mental health working as a supervisor.

i) Refrain from providing other services to participants which would be viewed by the Department as a conflict of interest;

j) Be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs which are applicable to participants;

k) Maintain information on current resources for mental health, medical, social, financial assistance, vocational, educational, housing, and other support services;

l) Safeguard the confidentiality of the participant's records in accordance with State and federal laws and regulations governing confidentiality;

m) Comply with the requirements for the delivery of mental health services outlined by the department.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: Providers must be selected through a competitive procurement process by the local Core Service Agency, in accordance with the 1915(b)(4) waiver. This process will ensure that every jurisdiction

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in the State is adequately prepared to offer high-quality, comprehensive case management services to eligible individuals.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs. This includes services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents;

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serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c).

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A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

A participant is eligible for care coordination services if the recipient:

Is in a federal eligibility category for Maryland Medical Assistance, which governs the determination of eligibility for the Maryland Medical Assistance Program. Services shall be provided to participants who are:

(1) Children and adolescents under 18 years with a serious emotional disturbance, or co-occurring mental health and substance use disorders diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary;

OR

(2) Young adults with a serious emotional disturbance or co-occurring disorder diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary, who have been enrolled in case management services continuously since reaching age 18, and who require community treatment and support in order to prevent or address:

(a) Inpatient psychiatric or substance use treatment;

(b) Treatment in a residential treatment center (RTC);

(c) Treatment in a residential substance use treatment facility;

(d) An out-of-home placement;

(e) Emergency room utilization due to multiple behavioral health stressors;

(f) Homelessness or housing instability, including doubling up, or otherwise lacking in permanent, safe housing;

(g) Arrest or incarceration due to multiple behavioral health stressors; and/or

(h) Needs case management services to facilitate community treatment following:

(i) Release from a detention center or correctional facility; or
(ii) Discharge to the community from RTC placement or inpatient psychiatric unit.

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(3) Participants must additionally meet at least two of the following conditions:

(a) The participant is not linked to behavioral health, health insurance, or medical services;

(b) The participant lacks basic supports for education, income, shelter, and food;

(c) The participant is transitioning from one level of intensity to another level of intensity including transitions out of the following levels of service:
  (i) Inpatient psychiatric or substance use services;
  (ii) Residential treatment center;
  (iii) Any service specified in section 1915(i) of Maryland's State Plan.

(d) The participant needs care coordination services to obtain and maintain community-based treatment and services;

(e) The participant has a history of psychiatric hospitalizations or a history of repeated visits or admissions to emergency room psychiatric units, crisis beds, or inpatient psychiatric units due to multiple behavioral health stressors within the past 12 months; or

(f) The participant is enrolled in Maryland's 1915(i) program.

(4) Participants that decline services after reaching 18 years of age must re-enter case management services within 120 days to maintain eligibility

_X_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to **30** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State
___ Only in the following geographic areas

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

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B. Definition of services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Units of service are 15 minutes of contact, which may include face-to-face and non-face-to-face contacts with the participant or, if the participant is a minor, with the minor's parent or guardian; and indirect collateral contacts on behalf of the participant with other community providers. The maximum service limit is 60 units per month, which may be exceeded based on clinical review by the Department or its designee.

Targeted Case Management includes the following assistance:

(1) Comprehensive participant assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services, using the child and youth assessment tools designated by the Department.

(a) Initial assessment or reassessment involves the taking the client history, identifying the individual's needs, and reviewing information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual. This information may relate to the participant's mental health, social, familial, educational, cultural, medical, developmental, legal, vocational, and economic status to assist in the formulation of a Plan of Care (POC).

(b) The initial assessment or reassessment of the participant's needs and progress is facilitated by the care coordinator in partnership with a team, which includes the participant, family members, and friends of the participant, as appropriate, or, if the participant is a minor, the minor's parent or guardian, and community service providers, such as mental health providers, medical providers, social workers, and educators, as appropriate.

(c) Coordination and facilitation of the team:
(i) Identification of a location for the meeting that is suitable to the participant's needs;
(ii) Convened at least every six months, or more frequently, as clinically necessary or indicated by the plan of care;

(d) After an initial assessment, each participant shall be reassessed at a minimum of every six months.

(2) Development (and Periodic Revision) of a Specified Plan of Care

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(a) After the initial assessment is completed, a POC shall be developed based on the information obtained through the comprehensive screening and assessment tools approved by the Department.

(b) The Care Coordination Organization shall finalize the POC within 30 calendar days of notification of enrollment and submit it to the Department or its designee.

(c) Development of and updates to the POC will be youth and family-directed and managed through team meetings.

(d) The POC development process includes:
- (i) The team meeting, which includes the participant, and if the participant is a minor, the minor's parent or guardian, providers, family members, other interested persons, as appropriate, for the purpose of establishing, revising, and reviewing the POC;
- (ii) The development of the written, individualized POC based on the participant's strengths, needs, and progress toward outcome measures;
- (iii) Transitional care planning that involves contact with the participant or, if the participant is a minor, the minor's parent or guardian, or the staff of a referring agency, or a service provider who is responsible to plan for continuity of care from inpatient level of care or an out-of-home placement to another type of community service; and
- (iv) Discharge planning from care coordination, when appropriate and when the family is closer to their identified vision, needs have been met, and outcome measures achieved for care coordination have been achieved.

(e) After the POC is developed, it shall be updated as often as clinically indicated based on the strengths and needs of the participant but in no instance less than every six months, and within seven days following a crisis event.

(f) Requirements of the POC. The POC shall contain, at minimum:

- (i) A description of the participant's strengths and needs;
- (ii) The diagnosis(es) established as evidence of the participant's eligibility for services under this chapter;
- (iii) The goals of care coordination services to address the behavioral health, medical, social, educational, and other services needed by the participant, with expected target completion dates and proposed course of action;

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(iv) A crisis plan including the proposed strategies and interventions for preventing and responding to crises and the youth and family's definitions of what constitutes a crisis;

(v) Designation of the care coordinator with primary responsibility for implementation of the POC;

(vi) Signatures of the care coordinator and other team members, if appropriate;

(vii) Signatures of the participant and family indicating that the participant and family has actively participated in the development of the POC, had choice in the selection of services, providers, and interventions, when possible;

(viii) An ongoing record of contacts made on the participant's behalf; and

(ix) The following details for each recommended service the following Information, as appropriate:

a. Description of the service;
b. Service start date;
c. Estimated duration;
d. Frequency and units of service to be delivered;
e. The specific need or goal that the service is related to; and,
f. The provider name and contact information.

(g) The CCO shall facilitate team meetings to review and update the POC, which includes the following duties:

(i) Coordinate and facilitate the team, with team meetings convened at least every 45 days or more frequently as clinically indicated;

(ii) Record and keep notes at every team meeting that include the team members who were present, a summary of the discussion, any changes to the POC, and action items for follow up, and share them with the team members, including those who were not in attendance;

(iii) Update the POC to include change in progress, services, or other areas within five days of the team meeting;

(iv) Ensure that the care coordinator facilitates team meetings, access to the services and supports in the POC, administers the appropriate assessments, and works with the participant and family to develop an

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initial crisis plan that includes response to immediate service needs; and

(v) Provide an overview of the wraparound process for those enrolled in a wraparound model of services.

(3) Referral and Related Activities.
The care coordinator shall assure that the participant, or, if the participant is a minor, the minor's parent or guardian, has applied for, has access to, and is receiving the necessary services available to meet the participant's needs as specified in the POC, such as mental health services, resource procurement, transportation, or crisis intervention. The care coordinator shall take the necessary action when this has not occurred. The linkage process shall include:

(a) Community and natural support development by contacting, with the participant's consent, members of the participant's support network, including team members, for example, family, friends, and neighbors, as appropriate, or, if the participant is a minor, the minor's parent or guardian, to mobilize assistance for the participant;

(b) Crisis intervention by referral of the participant or, if the participant is a minor, the minor's parent or guardian, to services on an emergency basis when immediate intervention is necessary;

(c) Linking the participant to transportation to and from services;

(d) Outreach in an attempt to locate service providers which can meet the participant's needs, or, if the participant is a minor, the minor's parent or guardian's needs for the child or adolescent;

(e) Reviewing the POC with the participant and the participant's team, as appropriate, or, if the participant is a minor, with the minor's parent or guardian, so as to enable and facilitate their participation in the plan's implementation; and

(f) Providing linkages to health and wellness education, information, high-quality health care services, preventive and health promotion resources, and chronic disease management services with an emphasis on resources available in the family's community and peer group; and,

(4) Monitoring and Follow-up Activities

(a) A CCO shall monitor the activities and contacts that are considered necessary to ensure the POC is implemented and adequately addresses the participant's needs, and include:

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(i) The participant, or if the participant is a minor, the minor's parent or guardian;
(ii) With proper consent, family members and friends, if appropriate; and
(iii) Other individuals or agency representatives identified and approved as team members by the participant, or if the participant is a minor, the minor's parent or guardian; and
(iv) Other service providers, if any.

(b) The CCO shall:
(i) Follow up any service referral within seven days to determine whether the participant, or if the participant is a minor, the minor's parent or guardian made contact with the service provider that the participant was referred to; and
(ii) Monitor service provision on an ongoing basis, and including at least one annual monitoring, to ensure that the agreed-upon services are provided, are adequate in quantity and quality, and meet the participant's needs and stated goals, or, if the participant is a minor, the parent's or guardian's stated needs and goals for the participant.
(iii) Revise the POC to reflect the participant's changing needs.
(iv) Engage in participant advocacy, including:
i. Empowering the participant and, if the participant is a minor, the minor's parent or guardian, to secure needed services;
ii. Taking any necessary actions to secure services on the participant's behalf; and
iii. Encouraging and facilitating the participant's decision-making and choices leading to accomplishment of the participant's goals or, if the participant is a minor, encourage the parent or guardian to carry out these decisions.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

C. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
The local mental health authority, called core service agencies (CSA), are agents of county government who are responsible for planning and coordinating mental health services at the local level. CSAs shall select child and youth Care Coordination Organizations (CCOs)s through a competitive procurement process, at least once every five years. Regional CCOs may be procured at the mutual agreement of local core service CSA so long as the local CSAs demonstrate that there is sufficient provider capacity to serve the children and youth in a particular region. The CCO must demonstrate a minimum of three years of experience providing care coordination

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i. Arrange for the participant and family to meet with peer support partners within 30 days of notification of enrollment to allow the participant and family the opportunity to determine the role of peer support in the development and implementation of the POC;
ii. Arrange for the participant and family to meet with the intensive in- home service (IIHS) provider to develop the initial crisis plan within one week of enrollment in the 1915(i);

h. Shall assure that:
i. A participant's initial assessment is completed within 10 days after the participant has been authorized by Department and determined eligible for, and has elected to receive, care coordination services; and
ii. An initial POC is completed within 15 days after completion of the initial assessment;

i. Maintain an electronic health record for each participant which includes all of the following:
i. An initial referral and intake form with identifying information, including, but not limited to, the individual's name and Medicaid identification number;
ii. A written agreement for services signed by the participant or the participant's legally authorized representative and by the participant's care coordinator; and
iii. An assessment as specified in Section D(1) above
iv. A POC as specified in Section D(3) above

j. Have formal written policies and procedures, approved by the Department, or the Department's designee, which specifically address the provision of care coordination to participants in accordance with the requirements of this chapter;

k. Be available to participants and, as appropriate, their families or, if the participant is a minor, the minor's parent or guardian, for 24 hours a day, seven days a week in order to refer
i. Participants to needed services and supports; and
ii. In the case of a behavioral health emergency, participants to behavioral health treatment and evaluation services in order to divert the participant's admission to a higher level of care;

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services. Once selected, the CCO shall be approved and commit to cording with all agencies involved in the participant's POC, including State and local child- and family-serving agencies to develop a network of clinical and natural supports in the community to address strengths and needs identified in each POC.

To be eligible to be approved as a care coordination organization, an entity shall meet all the following:

1. General requirements for participation in the Program are that a CCO shall be enrolled as a Medicaid provider and meet all the conditions for participation as required by the state,
2. Specific requirements for participation in the Program as CCO include all of the following:
    a. Place no restrictions on the participant's, or if the participant is under 16 years of age, the participants parent or guardian's right to elect to or decline to:
        i. Receive care coordination as authorized by the Department; and
        ii. Choose a care coordinator, as approved by the Department, and other care providers
    b. Employ appropriately qualified individuals as care coordinators, and care coordinator supervisors with relevant work experience, including experience with the populations of focus, including but not limited to:
        i. Minors with a serious emotional disturbance or co-occurring disorder
        ii. Youth with a serious emotional disturbance or co-occurring disorder.
    c. Shall assign care coordinators to the participant and family
    d. Schedule a face-to-face meeting with the participant and family within 72 hours of notification of the participants enrollment in Care Coordination services;
    e. Convene the first team meeting within 30 calendar days of notification of enrollment to develop the POC
    f. Collect information gathered during the application process including results from the physical examination, psychosocial and psychiatric screening, assessments, evaluations, and information from the team, participant, family, and the identified supports to be incorporated as a part of POC development process;
    g. Arrange for the participant and family to meet with applicable providers to determine their role in development and implementation of the POC. This includes, for participants receiving services specified in section 1915(i) of Maryland's state plan:

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State/Territory: Maryland

TARGETED CASE MANAGEMENT SERVICES:
Care Coordination for Children and Youth

(l) Shall document in the participant's care coordination records if the participant declines care coordination services or if a service is terminated because it was not working;

(m) May not provide other services to participants that would be viewed by the Department as a conflict of interest;

(n) Shall be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs that are applicable to participants;

(o) Shall maintain information on current resources for behavioral health, medical, social, financial assistance, vocational, educational, housing, and other support services including informal community resources;

(p) Shall safeguard the confidentiality of the participant's records in accordance with State and federal laws and regulations governing confidentiality;

(q) Shall comply with the Department's fiscal and program reporting requirements and submit reports in the manner specified by the Department to the Department;

(r) Shall provide services in a manner consistent with the best interest of recipients and may not restrict an individual's access to other services;

(s) Shall assure the amount, duration, and scope of the care coordination activities are documented in a participant's POC, which includes care coordination activities before discharge and after discharge when transitioning from an institution, to facilitate a successful transition into the community; and

(t) Commit to coordinating with all agencies involved in the participant's POC.

(2) Designate specific qualified staff including:

(a) Care coordinator supervisor who:

(i) Is a mental health professional with a minimum of a Master's degree and who is licensed and legally authorized to practice under the Health Occupations Article, Annotated Code of Maryland, and who is licensed under Maryland Practice Boards in the profession of:

a. Social work;
b. Professional Counseling;
c. Psychology;

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TARGETED CASE MANAGEMENT SERVICES:
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d. Nursing; or
e. Medicine

(ii) Has a minimum of one year of experience in behavioral health working as a supervisor;

(iii) Has a minimum of one year of experience working with children and youth with mental health or co-occurring disorders;

(iv) Provides clinical consultation and training to care coordinators regarding mental health or co-occurring disorders;

(v) Provides supervision of the POCs, and consultation to the CFT meetings, as needed;

(vi) Is employed or contracted at a ratio of one supervisor to every eight care coordinators;

(vii) Meets training and certification requirements for care coordinator supervisors, as set by the Department.

(b) Care coordinator has at least a:

(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 CFT meetings.

(3) Required criminal background checks. The provider shall, at the provider's own expense and for all staff, volunteers, students, and any individual providing Care Coordination services to participants and their families:

(a) Before employment, submit an application for a child care criminal history record check to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services (DPSCS); and

(b) Request that DPSCS send the report to:

(i) The director of the agency if the request is from a provider agency concerning staff, volunteers, students, or interns who will work with the participant or family; or

(ii) To the Department's designee, if the provider is a self-employed, independent practitioner, or the director of the agency;

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(iii) Review the results of the background checks; and

(iv) Store background checks in a secure manner consistent with State and federal law; and

(v) Maintain written documentation in the individual's personnel file that the director and all direct service provider staff including, but not limited to, volunteers, interns, and students, meet all requirements.

(4) Prohibitions against utilization of staff. The provider shall:

(a) Unless waived by the Department, prohibit from working with the participant or the participant's family any staff, volunteers, students, or any individual who is:

(i) Convicted of, received probation before judgment, or entered a plea of *nolo contendere* to a felony or a crime of moral turpitude or theft or have any other criminal history that indicates behavior which is potentially harmful to participant; or

(ii) Be cited on any professional licensing or certification boards or any other registries with a determination of abuse, misappropriation of property, financial exploitation, or neglect.

(iii) Has an indicated finding of child abuse or neglect.

(5) Waiver of Employment Prohibitions. The Department may waive the prohibition against working with the participant or the participant's family if the provider submits a request to the Department together with the following documentation that:

(a) For criminal background checks:

(i) The conviction, the probation before judgment, or plea of *nolo contendere* to a felony or crime involving moral turpitude or theft was entered more than 10 years before the date of the employment application;

(ii) The criminal history does not indicate behavior that is potentially harmful to participants; and

(iii) Includes a statement from the individual as to the reasons the prohibition should be waived; and

(b) For abuse and neglect findings:

(i) The indicated finding occurred more than seven years before the date of the clearance request;

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(ii) The summary of the indicated finding does not indicate behavior that is potentially harmful to the participant or the participant's family; and

(iii) Includes a statement from the individual as to the reasons the prohibition should be waived.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
_X_ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Providers must be selected through a competitive procurement process by the local Core Service Agency, in accordance with the State's 1915(b)(4) waiver. This process will ensure that every jurisdiction in the State is adequately prepared to offer high-quality, comprehensive case management services to eligible individuals.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case

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management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State of Maryland
PACE State Plan Amendment

Name and address of State Administering Agency, if different from the State Medicaid Agency.

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: A Special Income level equal to 300% of the SSI Federal Benefit (FBR) (42 CFR 435.217)

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. ____ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1.____The following standard included under the State plan (check one):
   (a) _____SSI
   (b) _____Medically Needy
   (c) _____The special income level for the institutionalized
   (d) _____Percent of the Federal Poverty Level: _____%
   (e) _____Other (specify):_____
   2._____The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
   3._____The following formula is used to determine the needs allowance:
   _____
   _____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5.____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ The amount is determined using the following formula:
_____
_____
7.____ Not applicable (N/A)

(C.) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

4.____ The following percentage of the following standard that is not greater than the standards above:_____%
of_____ standard.

5.____ The amount is determined using the following formula:

_____

_____

6.____ Other

7.____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1.___The following standard included under the State plan (check one):
   (a) _____SSI
   (b) _____Medically Needy
   (c) _____The special income level for the institutionalized
   (d) _____Percent of the Federal Poverty Level: _____%
   (e) _____Other (specify):_____
2.___The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
3___The following formula is used to determine the needs allowance:

_____

_____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):

1._____The following standard under 42 CFR 435.121:

_____

2._____The Medically needy income standard

_____

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

5._____The amount is determined using the following formula:

_____

_____

6._____Not applicable (N/A)

(C.) Family (check one):

1.____AFDC need standard

2_____Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5.____ The amount is determined using the following formula:

_____

_____

6.____ Other

7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward

the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

A).____The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B).____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

(C)__X__The following formula is used to determine the needs allowance:

300% of SSI for PACE enrollees living at home. For PACE enrollees living in assisted living, $60 for personal needs and $420 to pay the facility for room and board

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:
We believe that individuals who are maintaining a community residence on an income at or below 300% of SSI require all of their income to meet routine household and personal expenses. For PACE enrollees living in assisted living the same post-eligibility rules are used as for the Older Adults Waiver, with the enrollee expected to pay for room and board and towards the cost of care while retaining $ 60 for personal needs.

II. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting

methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. _X_ Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

State of Maryland
PACE STATE PLAN
Rate-setting Methodology

The Department calculates the capitation rates for the PACE program using an Amount that Would Otherwise been Paid (AWOP) analysis, applying service-category specific cost trends to derive a per-member per-month amount for defined coverage groups reflecting age, gender, and region of the eligible population.

The methodology establishes a base period of two consecutive fiscal years' worth of data that reflect the trended Medicaid fee for service (FFS) costs of a population eligible for the PACE program, i.e., persons aged 55 and older, certified medically eligible for nursing facility level of care, and living within the PACE Organization's designated service area. Beginning with Calendar Year 2023, data will be gathered and rates calculated for each of the regions listed below, so that the costs used to develop PACE rates reflect these regions:

1) Baltimore Metro - Baltimore City and Anne Arundel, Baltimore, Cecil, Carroll, Harford, and Howard counties
2) Washington Metro - Calvert, Charles, Frederick, Montgomery, Prince George's, and St. Mary's counties
3) Rural - Allegany, Garrett, Washington, Caroline, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties

Participants already enrolled in Medicaid managed care programs (including PACE) are excluded from the comparison base. No adjustments for administrative costs associated with PACE are included, and certain categories of costs not associated with a PACE-eligible, nursing facility-certified population are excluded from the claims data.

To develop annual PACE rates, the Department re-bases the claims period by moving it forward one year, such that one year of the current two-year base period will have been included in the previous year's base. Each of the two base years' data is trended forward by category of service (i.e., acute care based upon the latest trend information for Medicaid costs, nursing facility costs based on the latest changes in nursing home rates, and home health and special service costs based on the latest available Medicaid FFS experience for the PACE-eligible participants).

Calculation of Capitation Rates

The two years of trended data are combined to calculate costs on a per-member per-month basis, subtotaled by age (under- or over-65), by eligibility group, and weighted by the expected mix of program participants receiving long term care services in institutional compared to community-based settings. The rates are then reduced by an assumption of 2% savings attributed to managed care, and blended rates determined, according to the appropriate rate categories.

REQUIREMENTS AND LIMITS
APPLICABLE TO SPECIFIC SERVICES

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Early Intervention Services
Case Management

A. Target Group:

(See attachment)

B. Areas of State in Which Services Will Be Provided:

X Entire State

___ Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

___ Services are provided in accordance with § 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

D. Definition of Services:

(See attachment)

E. Qualifications of Providers:

(See attachment)

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

TN No. 91-11 Approval Date MAY 15 1991 Eff. Date NOV 19 1990

Supersedes TN No. ____

REQUIREMENTS AND LIMITS
APPLICABLE TO SPECIFIC SERVICES

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

H. Reimbursement Methodology:

See Attachment 4.19 A & B, Page 50

A. Target Group: Children between the ages of birth and up to age three years who are federally eligible Medical Assistance recipients and:

1. Are experiencing developmental delays as measured and verified by diagnostic instruments and procedures approved by the Maryland Infants and Toddlers Program, which indicate that the child is functioning at least 25 percent below chronological age in at least one of the five developmental areas of cognitive development, physical development (including fine and gross motor and sensory development), speech and language development, psychological development, and self-help skills;

2. Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, as described in (1) above; or

3. Demonstrate atypical development or behavior, which is demonstrated by abnormal quality of performance and function in at least one of the five developmental areas, interferes with current development, and is likely to result in future developmental delay, as described in (1) above.

Participation is conditional upon an election statement signed by the parent and filed with the chosen early intervention services (EIS) case management (CM) provider, which admits the child to early intervention services case management. Also, the child may not be receiving the same case management services under another Program authority and must be determined by a multidisciplinary team to be eligible for early intervention services.

D. Definition of Services:

1. Case management means services which will assist participants in gaining access to the full range of Medical Assistance services, as well as to any additional needed medical, social, mental health, financial assistance, counseling, educational, and other support services.

The Maryland Medical Assistance Program reimburses for the following services under early intervention services case management, when they have been documented as necessary and appropriate.

2. Initial case management services. A unit of service is defined as a completed initial Individualized Family Service Plan (IFSP) and at least one contact with the participant or the participant's family, in the participant's behalf.

The covered services shall include convening and conducting a multidisciplinary team to perform a multidisciplinary assessment and to develop an initial IFSP for the participant that will identify the:

(a) Participant's needs for early intervention, medical, mental health, social, educational, financial assistance, counseling, and other support services,

(b) Responsibilities and rights of the participant and the family,

(c) EIS CM provider's responsibilities, and

(d) Resources available to provide the needed services.

3. Ongoing Case Management Services.

(a) Ongoing case management service is provided subsequent to initial case management services.

(b) A unit of service includes a monthly telephone call to or visit with the participant's family, in the participant's behalf, and all other necessary covered services.

(c) These services shall include:

(i) Maintaining contact with the participant and the family through home visits, office visits, telephone calls, and follow-up services as necessary;

(ii) Referring the participant to direct service providers; assisting the participant in gaining access to services specified in the IFSP; and providing linkage to agreed-upon direct service providers of early intervention services;

(iii) Discussing with direct service providers of early intervention services the services needed and available for the participant, determining the quality and quantity of service being provided, following up to identify any obstacles to the participant's utilization of services, coordinating the service delivery, and performing ongoing monitoring to determine whether the recommended services are being delivered and meet the participant's current needs;

(iv) Providing the participant's family with information and direction that will assist the participant in successfully accessing and utilizing the services recommended in the IFSP;

(v) Informing the participant's family of the participant's and their rights and responsibilities in regard to specific programs and resources;

(vi) Conducting, with the participant's family, a periodic review of the participant's IFSP every 6 months, or more frequently if conditions warrant or the family requests such a review;

(vii) A periodic review accomplished at a meeting or by other means acceptable to the family and others involved in the review process, and which shall determine the following:

(aa) The degree of the participant's progress toward achieving the goals established in the IFSP, and

(bb) Whether the goals or recommended services need to be revised; and

(viii) Being available to the participant and the family on a nonscheduled basis as necessary for problem resolution and crisis management related to the participant's needs.

4. Annual IFSP Review.

(a) A unit of service is defined as a completed annual IFSP review and at least one contact with the participant or the participant's family, in the participant's behalf.

(b) The covered services include convening and conducting a multidisciplinary team to perform a multidisciplinary reassessment and to review, and revise as necessary, the participant's IFSP.

E. Qualifications of Early Intervention Services Case Management Providers

1. Professionals participating as EIS case managers employed by an EIS CM provider (e.g. social workers, registered nurses, audiologists, nutritionists, occupational therapists, physical therapists, clinical psychologists, school psychologists, special educators, speech language pathologists, physicians, and professional counselors) must be licensed or certified according to the respective authoizing regulations for the state in which the services are rendered.

2. General requirements for participation in the Maryland Medical Assistance Program are that providers shall:

(a) Verify the licenses and credentials of all individuals employed by the provider for performing the covered services;
(b) Apply for participation as a Program provider, using an application form designated by the Department;
(c) Have a signed provider agreement in effect with the Department;
(d) Be approved for participation by the Department;
(e) Be identified as a Program provider by issuance of a provider account number;
(f) Agree to verify a participant's eligibility for Medical Assistance each time service is provided;
(g) Accept payment by the Program as payment in full for services rendered to eligible participants and make no additional charge to a person for the specified covered services;
(h) Provide services without regard to race, color, sex, national origin, marital status, or physical or mental handicap;
(i) Maintain adequate records concerning service provision for a minimum of 6 years and make them available upon request to the Department or its designee;
(j) Agree to refrain from knowingly employing, contracting with, or having a written agreement with a person, partnership, or corporation which the Program has disqualified from providing or supplying services to recipients;
(k) Agree that, if the Program denies payment or requests repayment due to the provider's violation of program requirements, the provider may not seek payment from the participant or the participant's parent or family;
(l) Place no restrictions on the right of the participant's parent or family to choose a provider in the participant's behalf;

(m) Maintain a file on each participant which meets the Program's requirements and which includes for each contact made by the EIS case manager:

(i) Date and subject of contact.

(ii) Person contacted.

(iii) Person making the contact.

(iv) Nature, content, and unit or units of service provided, and

(v) Place of service; and

(n) Agree that if the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary, the provider may not seek payment for that service from the participant or the participant's parent or family.

3. Specific requirements for participation in the Program as an early intervention services case management provider are that the provider shall:

(a) Be the State agency (i.e. Children's Medical Services) administering a program of services for children with special health care needs, authorized under Title V of the Social Security Act, in conjunction with its local health department designees;

(b) Employ appropriately qualified individuals as EIS case managers;

(c) Have demonstrated expertise in providing family-centered, community-based, coordinated care to children with developmental delays, with an emphasis on early intervention services;

(d) Be selected by the participant's parent from among EIS CM designees;

(e) Contact the participant's family within 2 working days of the receipt of a referral for EIS CM services, unless client- related extenuating circumstances are documented;

(f) Develop the IFSP within 45 working days of referral, unless client-related extenuating circumstances are documented;

(g) Have formal written policies and procedures, approved by the Department, which specifically address the provision of early intervention services case management to participants in accordance with Program requirements;

(h) Be available to participants and their families for at least 8 hours a day, 5 days a week, except on State holidays;

(i) Designate specific qualified staff as early intervention services case managers;

(j) Maintain on file an initial IFSP for each participant and any subsequent revised IFSPs;

(k) Be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs which are applicable to participants;

(l) Maintain a current listing of medical, social, mental health, financial assistance, education, training, counseling, and other early intervention and support services available to infants and toddlers with developmental delays; and

(m) Strictly safeguard the confidentiality of the participant's records, so as not to endanger the participant's and the family's legal rights, family relationships, and status in the community.

4. An EIS case manager, employed by an EIS CM provider, shall meet the following requirements:

(a) Be a professional who:

(i) Has a current license or certification, according to E.1, of this section, in the profession most immediately relevant to the participant's needs,

(ii) Has demonstrated training or experience in providing case management or other early intervention services to infants and toddlers with developmental delays,

(iii) Meets by October 1, 1995 the qualifications applicable to the case manager's profession for individuals providing early intervention services, as specified in personnel standards for early intervention services providers issued by the Maryland Infants and Toddlers program, and

(iv) Participates in ongoing training offerings, as specified in the interagency training plan for early intervention services; or

(b) Be a nonprofessional who:

(i) Has a high school diploma or its equivalency,

(ii) Has demonstrated training or experience in providing case management or other early intervention services to infants and toddlers with developmental delays, and

(iii) Participates in ongoing training offerings, as specified in the interagency training plan for early intervention services.

State Plan under Title XIX of the Social Security Act
State/Territory: Maryland

TARGETED CASE MANAGEMENT SERVICES FOR People with intellectual and developmental disabilities On DDA Waiting List

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Services shall be provided to Medicaid participants who:

1) Have applied for services from the Developmental Disabilities Administration (DDA); and

2) Have been determined to have a developmental disability from the DDA on the DDA Waiting List.

_X_ Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL, July 25, 2000)).

B. Areas of State in which Services Will Be Provided (§1915(g)(1) of the Act):

_X_ Entire State

__ Only in the following geographic areas: [Specify areas:]

C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration and scope (§1915(g)(1)).

D. Definition of Services (42 CFR 440.169)

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- x Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - o Taking client history; and
  - o Identifying the individual's needs and completing related documentation; and
  - o Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

- The initial comprehensive assessment will be completed when the individual initially seeks services. Periodic reassessment of the individual's needs are conducted minimally annually during the annual Individual Plan meeting or more frequently based on the needs of the person;

x Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of eligible individuals;

x Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable or providing needed services to address identified needs and achieve goals specified in the care plan; and

X Monitoring and follow-up activities:
o Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family member, service providers, or other entities or individuals and conducted as frequently as necessary, and including monitoring, to determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- Changes in the needs or status of the individual are reflected in the service plan. Monitoring and follow up activities include making necessary adjustments in the care plan and services arrangement with providers.

Monitoring activities shall occur on the following minimum frequency based on DDA priority categories:

- Crisis Resolution – minimum monthly contacts for first ninety (90) days and then quarterly until priority category changes, unless additional contacts otherwise authorized by DDA; or services offered; or
- Crisis Prevention – minimum quarterly contacts until priority category changes, unless additional contacts otherwise authorized by the DDA, or services offered; or
- Current Request – minimum annual contact until priority contact changes, unless additional contacts otherwise authorized by DDA, or services authorized.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the individual access services, identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CRF 440.169(e)).

E. Qualifications for Providers (42 CFR 441.18(a)(8)(V) and 42 CFR 441.18(b))
Provider agencies are certified for providing targeted case management known as Coordination of Community Services to people eligible for funding from the Developmental Disabilities Administration (DDA).

DDA-certified Coordination of Community Services providers will include private providers and/or local health departments.

At a minimum, prior to becoming a certified provider, potential providers must:

1. Be incorporated in the State unless operating as a local health department;
2. Have a board of directors or local advisory board in accordance with the regulations;
3. Submit and have approved by DDA or its designee the following:
    a. Application
    b. Business Plan which demonstrates fiscal viability; and
    c. Program Service Plan to include scope of work and proposed staffing plan; and including staff and staff to participant ratios; and
    d. Formal written Policies and Procedures; and
    e. Formal written Quality Assurance Plan; and
    f. Documentation of strategies for locating community-based public, private, and generic resources; and
    g. Prior licensing reports issued within the previous ten years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
4. Comply with all State and Federal statutes and regulations.
5. All providers must be enrolled as a Medicaid provider and meet all the conditions for participation as set forth in regulations.

Ineligibility for Employment
An individual is ineligible for employment by a Coordination of Community Services provider organization or entity in Maryland if the individual:

1. Is simultaneously employed by any MDH-licensed provider organization and entity;
2. Is on the Maryland Medicaid exclusion list;
3. Is on the federal List of Excluded Individuals/Entities (LEIE);
4. Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV);
5. Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland;

6. Violates or has violated Health-General Article, §7-1102, Annotated Code of Maryland, unlawfully interfering with the rights of an individual with a developmental disability; or
7. Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to individuals receiving services, as documented either through a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902, et seq., Annotated Code of Maryland.

Private DDA-certified Coordination of Community Services providers must:

1. Refrain from providing direct services to people receiving funding within the DDA service delivery system including Meaningful Day, Support, and Residential Services;
2. Refrain from providing case management services to any persons receiving direct services from a parent company, subsidiary, or otherwise affiliated company; and
3. Provide services in all areas of their authorized jurisdiction.

All DDA certified Coordination of Community Services providers (including local health departments) must:

1. Use the Maryland Long Term Services and Supports (LTSS*Maryland*) electronic information system to document service activities, complete required forms, and submit billing claims ; and
2. Maintain a standard 8-hour operational day Monday through Friday and have flexible staffing hours that include nights and weekends to accommodate the needs of individuals receiving services; and
3. Have a means for individuals, their families, community providers, and DDA staff to contact the case management designated staff directly in the event of an emergency and at times other than at standard operating hours; and
4. Maintain a toll free number unless otherwise authorized by DDA and communication system accessible for everyone receiving case management services; and
5. Be knowledgeable of the eligibility requirements, application procedures, and scope of services of federal, State, and local government assistance programs which are applicable to participants; and
6. Have a management team with at least three (3) years experience each providing case management services or management experience in human services; and
7. Have no legal sanctions or judgments within the past ten (10) years.

F. DDA Coordination of Community Services Staff Qualifications:

Coordination of Community Services Supervisor

The Coordination of Community Services supervisor is an individual who is employed to provide oversight of case management services rendered and performance of case managers, and who has:

1. An advanced degree in human services and one (1) year experience or a Bachelor's degree in human services with three (3) years experience; except for Coordination of Community Services Supervisors employed for a minimum of one (1) year by January 1, 2014 with an existing DDA certified Coordination of Community Services agency can be grandfathered as a qualified Coordination of Community Services Supervisor in lieu of education requirement noted above.
2. Experience in any one or more of the following:
   a. Coordinating services for people in Medicaid and/or waiver programs
   b. Coordinating services for people with Intellectual/Developmental Disabilities
3. Demonstrated skills and working knowledge in:
   a. Social services intake and referral services; and
   b. Data collection, analysis, and reporting; and
   c. Staff supervision; and
   d. Management or leadership
4. Supervised the work of case managers
5. Monitored the quality of services provided.

Coordinator of Community Services

The Coordinator of Community Services is an individual employed by the case management agency to assist authorized individuals in selecting and obtaining the most responsive and appropriate services and supports, and who meet the following criteria:

1. Educational Requirements:
   a. Bachelor's degree in a human service field;
   b. Associated degree with two (2) years' experience in human service field;
   c. Seven (7) years' experience in human service field; or
   d. Employed for a minimum of one (1) year by January 1, 2014 with an existing DDA-certified Coordination of Community Services agency who were grandfathered as a qualified Coordinator of Community Services in lieu of education requirements noted above
2. Uses all communication methodologies, strategies, devices and techniques necessary, including sign language, assistive technology, or language interpreter services, to facilitate the involvement of the participant in the assessment, development, and monitoring of services and supports;
3. Ensure that each individual receives a person-centered plan that is designed to meet the individual's needs and in the most cost effective manner; and
4. Annually advise participants of their right to choose among qualified providers of services to include Coordination of Community Services.

G. Staff Training Requirements

1. All DDA-certified Coordination of Community Services, providers must ensure through appropriate documentation that Coordination of Community Services, Supervisors, and Quality Assurance staff receives training as required by DDA.
2. All Coordination of Community Services staff shall receive re-training as required by the DDA.

H. Freedom of Choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b))

___ Target group consists of eligible participants with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

I. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3) and 42 CFR 441.18(a)(6))

The State assures the following:

- x Case management (including targeted case management) services will not be used to restrict a person's access to other services under the plan.
- x Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- x Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

J. Payment (42 CFR 441.18(a)(4))
Payment for DDA Coordination of Community Services (or targeted case management) services under the plan does not duplicate payments made to public agencies or private entities under other program authorizes for this same purpose.

K. Case Records (42 CFR 442.18(a)(7))
Providers maintain case records that document for all individuals receiving case management services as follows: (i) the name of the individual; (ii) the dates of the services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; (viii) a timeline for reevaluation of the plan.

L. Limitations
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

State Plan under Title XIX of the Social Security Act
State/Territory: Maryland

TARGETED CASE MANAGEMENT SERVICES FOR People with intellectual and developmental disabilities Transitioning to the Community

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Services shall be provided to Medicaid participants who:

1) Have applied for services from the Developmental Disabilities Administration (DDA); and

2) Have been determined to have a developmental disability from the DDA and are transitioning to the community

_X_ The target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL, July 25, 2000)).

B. Areas of State in which Services Will Be Provided (§1915(g)(1) of the Act):

_X_ Entire State

_ _ Only in the following geographic areas: [Specify areas:]

C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration and scope (§1915(g)(1)).

D. Definition of Services (42 CFR 440.169)

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - Taking client history;
  - Identifying the individual's needs and completing related documentation; and

- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  The initial comprehensive assessment will be completed when the individual initially seeks services. Periodic reassessment of the individual's needs are conducted minimally annually during the annual Individual Plan meeting or more frequently based on the needs of the person;

x Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of eligible individuals;

x Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable or providing needed services to address identified needs and achieve goals specified in the care plan; and

x Monitoring and follow-up activities:
  - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family member, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - Services are being furnished in accordance with the individual's care plan;
    - Services in the care plan are adequate; and
    - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow up activities include making necessary adjustment in the care plan and services arrangement with providers.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the individual access services, identifying needs and supports to assist the eligible individual in obtaining

services; providing case managers with useful feedback, and alerting case managers to changes in the eligible person's needs. (42 CRF 440.169(e)).

E. Qualifications for Providers (42 CFR 441.18(a)(8)(V) and 42 CFR 441.18(b))
Provider agencies are certified agents responsible for providing targeted case management known as Coordination of Community Services to people eligible for funding from the Developmental Disabilities Administration (DDA).

DDA-certified Coordination of Community Services providers will include private providers and/or local health departments.

At a minimum, prior to becoming a certified provider, potential providers must:

1. Be incorporated in the State unless operating as a local health department;
2. Have a board of directors or local advisory board in accordance with the regulations;
3. Submit and have approved by DDA or its designee the following:
    a) Application
    b) Business Plan which demonstrates fiscal viability;
    c) Program Service Plan to include scope of work and proposed staffing plan; and including staff and staff to participant ratios; and
    d) Formal written Policies and Procedures; and
    e) Formal written Quality Assurance Plan; and
    f) Documentation of strategies for locating community-based public, private, and generic resources; and
    g) Prior licensing reports issued within the previous ten years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records;
4. Comply with all State and Federal statutes and regulations.
5. All providers must be enrolled as a Medicaid provider and meet all the conditions for participation as set forth in regulations.

Ineligibility for Employment
An individual is ineligible for employment by a Coordination of Community Services provider organization or entity in Maryland if the individual:

1. Is simultaneously employed by any MDH-licensed provider organization and entity;
2. Is on the Maryland Medicaid exclusion list;
3. Is on the federal List of Excluded Individuals/Entities (LEIE);
4. Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV);
5. Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland;

6. Violates or has violated Health-General Article, §7-1102, Annotated Code of Maryland, unlawfully interfering with the rights of an individual with a developmental disability; or
7. Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to individuals receiving services, as documented either through a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902, et seq., Annotated Code of Maryland.

Private DDA--certified Case Management providers must:

1. Refrain from providing direct services to people receiving funding within the DDA service delivery system including Meaningful Day, Support, and Residential Services;
2. Refrain from providing case management services to any persons receiving direct services from a parent company, subsidiary, or otherwise affiliated company; and
3. Provide services in all areas of their authorized jurisdiction.

All DDA--certified providers (including local health departments) must:

1. Use the Maryland Long Term Services and Supports (LTSS*Maryland*) electronic information system to document service activities, complete required forms, and billing claims;
2. Maintain a standard 8-hour operational day Monday through Friday and have flexible staffing hours that include nights and weekends to accommodate the needs of individuals receiving services;
3. Have a means for individuals, their families, community providers, and DDA staff to contact the case management designated staff directly in the event of an emergency and at times other than at standard operating hours;
4. Maintain a toll free number unless otherwise authorized by the DDA and communication system accessible for everyone receiving case management services;
5. Be knowledgeable of the eligibility requirements, application procedures, and scope of services of federal, State, and local government assistance programs which are applicable to participants;
6. Have a management team with at least three (3) years experience each providing case management services or management experience in human services;
7. Have had no legal sanctions or judgments within the past ten (10) years.

F. DDA Coordination of Community Services Staff Qualifications:

Coordination of Community Services Supervisor

The Coordination of Community Services supervisor is an individual who is employed to provide oversight of Coordination of Community Services rendered and performance of case managers, and who has:

1. An advanced degree in human services and one (1) year experience or a Bachelor's degree in human services with three (3) years' experience; except for Case Management Supervisors

employed for a minimum of one (1) year by January 1, 2014 with an existing DDA-certified Coordination of Community Services agency can be grandfathered as a qualified Coordination of Community Services Supervisor in lieu of education requirement noted above.

2. Experience in any one or more of the following:
   a. Coordinating services for people in Medicaid and/or waiver programs
   b. Coordinating services for people with Intellectual/Developmental Disabilities
3. Demonstrated skills and working knowledge in:
   a. Social services intake and referral services;
   b. Data collection, analysis, and reporting;
   c. Staff supervision; and
   d. Management or leadership
4. Supervised the work of case managers
5. Monitored the quality of services provided

Coordinator of Community Services

A Coordinator of Community Services is an individual employed by the Coordination of Community Services agency to assist authorized individuals in selecting and obtaining the most responsive and appropriate services and supports, and who meet the following criteria:

1. Educational requirements:
   a. Bachelor's degree in a human service field;
   b. Associated degree with two (2) years' experience in human service field;
   c. Seven (7) years' experience in human service field; or
   d. Employed for a minimum of one (1) year by January 1, 2014 with an existing DDA-certified Coordination of Community Services agency who were grandfathered as a qualified Coordinator of Community Services in lieu of education requirements noted above.
2. Uses all communication methodologies, strategies, devices and techniques necessary, including sign language, assistive technology, or language interpreter services, to facilitate the involvement of the participant in the assessment, development, and monitoring of services and supports;
3. Ensure that each individual receives a person-centered plan that is designed to meet the individual's needs and in the most cost effective manner; and
4. Annually advise participants of their right to choose among qualified providers of services to include Coordinator of Community Services.

G. Staff Training Requirements

1. All DDA-certified Coordination of Community Services providers must ensure through appropriate documentation that Coordinators of Community Services, Coordination of Community Services Supervisors and Quality Assurance staff receives training as required

by DDA.

2. All staff shall receive re-training as required by the DDA.

H. Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b))

___ Target group consists of eligible participants with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that participants with developmental disabilities or with chronic mental illness receive needed services.

I. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3) and 42 CFR 441.18(a)(6))

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict a person's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

J. Payment (42 CFR 441.18(a)(4))

Payment for DDA Coordination of Community Services services under the plan does not duplicate payments made to public agencies or private entities under other program authorizes for this same purpose.

K. Case Records (42 CFR 442.18(a)(7))

Providers maintain case records that document for all individuals receiving case management services as follows: (i) the name of the individual; (ii) the dates of the Case Management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; (viii) a timeline for reevaluation of the plan.

L. Limitations

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

State Plan under Title XIX of the Social Security Act
State/Territory: Maryland

TARGETED CASE MANAGEMENT SERVICES FOR
People with intellectual and developmental disabilities
Community Coordination Services

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Services shall be provided to Medicaid participants who:

1) Have applied for services from the Developmental Disabilities Administration (DDA); and
2) Receive funding for community-based services from the DDA.

_X_ The target group includes individuals needing community coordination services. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL, July 25, 2000)).

B. Areas of State in which Services Will Be Provided (§1915(g)(1) of the Act):

_X_ Entire State
___ Only in the following geographic areas: [Specify areas:]

C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount, duration and scope (§1915(g)(1)).

D. Definition of Services (42 CFR 440.169)

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - Taking client history;
  - Identifying the individual's needs and completed related documentation; and

- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
- The initial comprehensive assessment will be completed when the individual initially seeks services. Periodic reassessment of the individual's needs are conducted minimally annually during the annual Individual Plan meeting or more frequently based on the needs of the person;

x Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of eligible individuals;

x Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
- Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

x Monitoring and follow-up activities:
- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family member, service providers, or other entities or individuals and conducted as frequently as necessary, and including quarterly monitoring, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow up activities include making necessary adjustment in the care plan and services arrangement with providers.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the individual access services, identifying needs and supports to assist the eligible individual in obtaining

services; providing case managers with useful feedback, and alerting case managers to changes in the eligible person's needs. (42 CRF 440.169(e)).

E. Qualifications for Providers (42 CFR 441.18(a)(8)(V) and 42 CFR 441.18(b))
Provider agencies are certified agents responsible for providing targeted case management known as Coordination of Community Services to people eligible for funding from the Developmental Disabilities Administration (DDA).

DDA-certified Coordination of Community Services providers will include private providers and/or local health departments.

At a minimum, prior to becoming a certified provider, potential providers must:

1. Be incorporated in the State unless operating as a local health department;
2. Have a board of directors or local advisory board in accordance with the regulations;
3. Submit and have approved by DDA or its designee the following:
   a) Application
   b) Business Plan which demonstrates fiscal viability; and
   c) Program Service Plan to include scope of work and proposed staffing plan; and including staff and staff to participant ratios; and
   d) Formal written Policies and Procedures; and
   e) Formal written Quality Assurance Plan; and
   f) Documentation of strategies for locating community-based public, private, and generic resources; and
   g) Prior licensing reports issued within the previous ten years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
4. Comply with all State and Federal statutes and regulations.

All providers must be enrolled as a Medicaid provider and meet all the conditions for participation as set forth in regulations.

Ineligibility for Employment
An individual is ineligible for employment by a Coordination of Community Services provider organization or entity in Maryland if the individual:

1. Is simultaneously employed by any MDH-licensed provider organization and entity;
2. Is on the Maryland Medicaid exclusion list;
3. Is on the federal List of Excluded Individuals/Entities (LEIE);
4. Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV);
5. Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland;

6. Violates or has violated Health-General Article, §7-1102, Annotated Code of Maryland, unlawfully interfering with the rights of an individual with a developmental disability; or
7. Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to individuals receiving services, as documented either through a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902, et seq., Annotated Code of Maryland.

Private DDA-certified Coordination of Community Services providers must:

1. Refrain from providing direct services to people receiving funding within the DDA service delivery system for Meaningful Day, Support, and Residential Services;
2. Refrain from providing case management services to any persons receiving direct services from a parent company, subsidiary, or otherwise affiliated company; and
3. Provide services in all areas of their authorized jurisdiction.

All DDA-certified providers (including local health departments) must:

1. Use the Maryland Long Term Services and Supports (LTSS*Maryland*) electronic information system to document service activities, complete required forms, and submit billing claims; and
2. Maintain a standard 8-hour operational day Monday through Friday and have flexible staffing hours that include nights and weekends to accommodate the needs of individuals receiving services; and
3. Have a means for individuals, their families, community providers, and DDA staff to contact the case management designated staff directly in the event of an emergency and at times other than at standard operating hours; and
4. Maintain a toll free number, unless otherwise authorized by DDA, and communication system accessible for everyone receiving case management services; and
5. Be knowledgeable of the eligibility requirements, application procedures, and scope of services of federal, State, and local government assistance programs which are applicable to participants; and
6. Have a management team with at least three (3) years experience each providing case management services or management experience in human services; and
7. Have no legal sanctions or judgments within the past ten (10) years.

F. DDA Coordination of Community Services Staff Qualifications:

Coordination of Community Services Supervisor

The Coordination of Community Services supervisor is an individual who is employed to provide oversight of case management services rendered and performance of Coordinator of Community Services, and who has:

1. An advanced degree in human services and one (1) year experience or a Bachelor's degree in human services with three (3) years experience; except for individuals

employed for a minimum of one (1) year by January 1, 2014 with an existing DDA certified Coordination of Community Services agency can be grandfathered as a qualified Coordination of Community Services Supervisor in lieu of education requirement noted above.

2. Experience in any one or more of the following:
    a. Coordinating services for people in Medicaid and/or waiver programs
    b. Coordinating services for people with Intellectual/Developmental Disabilities

3. Demonstrated skills and working knowledge in:
    a. Social services intake and referral services; and
    b. Data collection, analysis, and reporting; and
    c. Staff supervision; and
    d. Management or leadership
4. Supervised the work of Coordinator of Community Services
5. Monitored the quality of services provided

Coordinator of Community Services

The Coordinator of Community Services is an individual employed by the Coordinator of Community Services agency to assist authorized individuals in selecting and obtaining the most responsive and appropriate services and supports, and who meet the following criteria:

1. Educational requirements:
    a. Bachelor's degree in a human service field;
    b. Associated degree with two (2) years' experience in human service field;
    c. Seven (7) years's experience in human service field; or
    d. Employed for a minimum of one (1) year by January 1, 2014 with an existing DDA-certified Coordination of Community Services agency who were grandfathered as a qualified Coordinator of Community Services in lieu of education requirements noted above.
2. Uses all communication methodologies, strategies, devices and techniques necessary, including sign language, assistive technology, or language interpreter services, to facilitate the involvement of the participant in the assessment, development, and monitoring of services and supports;
3. Ensure that each individual receives a person-centered plan that is designed to meet the individual's needs and in the most cost effective manner; and
4. Annually advise participants of their right to choose among qualified providers of services to include Coordinator of Community Services.

G. Staff Training Requirements

1. All DDA-certified Coordination of Community Services providers must ensure through appropriate documentation that Coordinators of Community Services, Coordination of

Community Services Supervisors, and Quality Assurance staff receives training as required by DDA.

2. All staff shall receive re-training as required by the DDA.

H. Freedom of Choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b))

__ Target group consists of eligible participants with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

I. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3) and 42 CFR 441.18(a)(6))

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict a person's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

J. Payment (42 CFR 441.18(a)(4))
Payment for DDA Coordination of Community Services (or targeted case management) services under the plan does not duplicate payments made to public agencies or private entities under other program authorizes for this same purpose.

K. Case Records (42 CFR 442.18(a)(7))
Providers maintain case records that document for all individuals receiving case management services as follows: (i) the name of the individual; (ii) the dates of the Case Management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature,

content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; (viii) a timeline for reevaluation of the plan.

L. Limitations

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Reimbursement Methodology for Targeted Case Management Services – On DDA Waiting List

1. Effective July 2, 2020, payments for Targeted Case Management services to the Community as defined per Section 3.1A, Supplement 7 shall be paid based on a fee-for-service schedule. The rate is the same for both governmental and private individual practitioners.

2. Initial Eligibility and Access Comprehensive Assessment is reimbursed at a flat rate of $450.

3. Effective July 2, 2020, the rate will be $20.72 per unit to reflect a planned FY 21 Cost of Living Adjustment (COLA). A COLA, authorized by Maryland State Legislature, effectively increases the rate for the State Fiscal Year 2021. A unit of service means a 15 minute increment.

4. Effective October 1, 2020, a geographical differential rates of $21.82 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:
   - Calvert County;
   - Charles County;
   - Frederick County;
   - Montgomery County; and
   - Prince George's County.

5. The State assures that billed time does not exceed available productive time by practitioner.

6. Services can be provided by qualified professionals that meet the qualifications outlined in Section 3.1A, Supplement 7, §F. DDA Case Management Staff Qualifications.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Reimbursement Methodology for Targeted Case Management Services – Transitioning to the Community

1. Effective July 2, 2020, payments for Targeted Case Management services to the Community as defined per Section 3.1A, Supplement 7 shall be paid based on a fee-for-service schedule. The rate is the same for both governmental and private individual practitioners.

2. Initial Eligibility and Access Comprehensive Assessment is reimbursed at a flat rate of $450.

3. Effective July 2, 2020, the rate will be $20.72 per unit to reflect a planned FY 21 Cost of Living Adjustment (COLA). A COLA, authorized by Maryland State Legislature, effectively increases the rate for the State Fiscal Year 2021. A unit of service means a 15 minute increment.

4. Effective October 1, 2020, a geographical differential rates of 21.82 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:
   - Calvert County;
   - Charles County;
   - Frederick County;
   - Montgomery County; and
   - Prince George's County.

5. The State assures that billed time does not exceed available productive time by practitioner.

6. Services can be provided by qualified professionals that meet the qualifications outlined in Section 3.1A, Supplement 7, §F. DDA Case Management Staff Qualifications.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Reimbursement Methodology for Targeted Case Management Services – Community Coordination Services

1. Effective July 2, 2020, payments for Targeted Case Management services to the Community as defined per Section 3.1A, Supplement 7 shall be paid based on a fee-for-service schedule. The rate is the same for both governmental and private individual practitioners.

2. Initial Eligibility and Access Comprehensive Assessment is reimbursed at a flat rate of $450.

3. Effective July 2, 2020, the rate will be $20.72 per unit to reflect a planned FY 21 Cost of Living Adjustment (COLA). A COLA, authorized by Maryland State Legislature, effectively increases the rate for the State Fiscal Year 2021. A unit of service means a 15 minute increment.

4. Effective October 1, 2020, a geographical differential rates of 21.82 per unit will apply for services rendered to individuals who live in specific Maryland counties. The geographic differentiated rate is for areas of the State where the cost of living is higher due to other cost pressures or economic factors including:
   - Calvert County;
   - Charles County;
   - Frederick County;
   - Montgomery County; and
   - Prince George's County.

5. The State assures that billed time does not exceed available productive time by practitioner.

6. Services can be provided by qualified professionals that meet the qualifications outlined in Section 3.1A, Supplement 7, §F. DDA Case Management Staff Qualifications.

Supplement 8 – future use

EXHIBIT I
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

CASE MANAGEMENT SERVICES
SERVICE COORDINATION FOR CHILDREN WITH DISABILITIES

A. Target Group:
(Modified to include autistic children enrolled in the Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder (COMAR 10.09.56) – see attached).

B. Areas of State in Which Services Will Be Provided:

X Entire State

_ Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

_ Services are provided in accordance with §1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

D. Definition of Services:
(Modified to include autistic children enrolled in the Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder (COMAR 10.09.56) – see attached).

E. Qualifications of Providers:
(Modified to include autistic children enrolled in the Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder (COMAR 10.09.56) – see attached).

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TN No. 02 – 12
Supersedes TN No. 02 – 3

Approval Date SEP 25 2002

Effective Date: April 1, 2002

A. Target Group

Children 2 through 20 years old who are federally eligible Medical Assistance recipients and for whom free and appropriate education is provided under the Individuals with Disabilities Education Act of the Rehabilitation Act of 1973.

Individuals enrolled as waiver participants in accordance with the requirements of the Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder (COMAR 10.09.56) and Service Coordination for Children with Disabilities under Maryland's Medical Assistance Program regulations (COMAR 10.09.52.02), who are age 1 through 21 years old, may receive specialized service coordination of their waiver services, in addition to regular service coordination.

A recipient is eligible to receive the case management services, called Service Coordination for Children with Disabilities under Maryland's Medical Assistance Program regulations (COMAR 10.09.52), when the following requirements are met:

1. It is determined through an assessment, in accordance with Maryland law and regulations for assuring a free, appropriate education for all students with disabilities, that:

   a. The recipient has temporary or long-term special education needs arising from cognitive, emotional, or physical factors, or any combination of these, and
   b. The recipient's ability to meet general education objectives is impaired to a degree whereby the services available in the general education program are inadequate in preparing the child to achieve his or her education potential;

2. A multidisciplinary team, called an Individualized Education Program (IEP) team in the Maryland State Department of Education regulations for Programs for Students with Disabilities (COMAR 13A.05.01), determines that the recipient is a child with disabilities who:

   a. Is eligible for Special Education ARD-related services, and
   b. Needs an IEP under Part B of the Individuals with Disabilities Education Act of the Rehabilitation Act of 1973.

3. The recipient elects, or the recipient's parent or other responsible individual elects, on the recipient's behalf, to receive Service Coordination for Children with Disabilities; and

4. The recipient is not receiving similar case management services under another Medical Assistance Program authority.

D. Definition of Services:

Service Coordination for Children with Disabilities means those case management services which will assist participants in gaining access to the services recommended in a participant's IEP.

A "unit of service" is defined as a completed initial waiver plan of care, approved by the Maryland State Department of Education (MSDE) and signed by the service coordinator, the waiver participant or the parent or parents of a minor child, and all other members of the waiver multidisciplinary team and the provision of all other services specified in COMAR 10.09.52.

The Maryland Medical Assistance Program reimburses for the following services under Service Coordination for Children with Disabilities, when the services have been documented as necessary and appropriate:

1. Initial IEP

a. A unit of service for the initial IEP is defined as:

(1) A completed initial Individualized Education Program (IEP) signed by all members of the IEP team, (i.e., the multidisciplinary team) and

(2) At least one contact by the participant's service coordinator (i.e., case manager) or IEP team in person or by telephone with the participant or the participant's parent or other responsible individual, on the participant's behalf, relating to development of the initial IEP.

b. The covered services include convening and conducting, the IEP team to perform a multidisciplinary assessment and develop an initial IEP that includes:

(1) A statement of the participant's special education needs and related service needs, including the need for medical, mental health, social, financial assistance, counseling, and other support services;

(2) A statement of measurable annual goals and measurable short-term objectives for the participant;

(3) A statement of the specific special education and related services to be provided to the participant;

(4) The projected dates for initiation of services and the anticipated duration of service; and

(5) Appropriate objective criteria and evaluation procedures for determining, on at least an annual basis, whether the objectives in the IEP are being achieved.

2. Ongoing Service Coordination

a. Ongoing Service Coordination (i.e., case management) is rendered subsequent to an initial IEP.

b. A unit of service for Ongoing Service Coordination includes:

(1) At least one contact by the Service Coordinator in person, by telephone, or through written notes with the participant or the participant's parent or other responsible individual, on the participant's behalf, relating to the child's Ongoing Service Coordination, and

(2) The provision of any other necessary covered services under Ongoing Service Coordination.

c. These services shall include any of the following services, as appropriate:

(1) Acting as a central point of contact relating to IEP services for a participant;

(2) Maintaining contact with direct service providers and with a participant and the participant's parent or other responsible individual through home visits, office visits, school visits, telephone calls, written progress notes and follow-up services as necessary;

(3) Implementing the IEP by referring the participant to direct service providers, assisting the participant in gaining access to services specified in the IEP, and providing linkage to agreed-upon direct service providers;

(4) Discussing with direct service providers the services needed and available for the participant, assessing the quality and quantity of services being provided, following up to identify any obstacles to a participant's utilization of services, coordinating the service delivery, and performing ongoing monitoring to determine whether the services are being delivered in an integrated fashion as recommended in the IEP and meet the participant's current needs;

(5) Providing a participant and a participant's parent or other responsible individual with information and direction that will assist them in successfully accessing and using the services recommended in the IEP;

(6) Informing a participant's parent or other responsible individual of the participant's and the family's rights and responsibilities in regard to specific programs and resources recommended in the IEP;

(7) Conducting, with a participant's parent or other responsible individual at a meeting or by other means acceptable to the parent and the service coordinator, a review of the participant's IEP every 6 months, or more frequently if warranted or the parent or other responsible individual requests a review; and

(8) Reviewing, at least annually at a meeting or by other means acceptable to the participant's parent and others involved in the review process:

(a) The degree of a participant's progress toward achieving the goals established in the IEP, and
(b) Whether the goals or recommended services need to be revised.

d. Administrative, supervisory, and monitoring services associated with the Ongoing Service Coordination, are included as part of the service.

3. IEP Review

a. Regulations of the Maryland State Department of Education require that a participant's IEP be reviewed and, if appropriate, revised:

(1) Within 60 school days after the participant's initial placement in Special Education;
(2) On an interim basis upon the request of the professionals on the IEP team or the request of the participant's parent(s) or other responsible individual; and
(3) At least annually.

b. A unit of service for IEP review is defined as:
(1) A completed 60-day, interim, or annual IEP review; and
(2) At least one contact by the service coordinator or IEP team in person or by telephone with the participant or the participant's parent or other responsible individual, on the participant's behalf, relating to review of the IEP.

c. The covered services include convening and conducting an IEP team to perform a multidisciplinary reassessment of the participant's status and to review and revise, as necessary, the participant's IEP.

4. Waiver Initial Assessment

(a) The covered service includes convening, coordinating, and participating on the waiver multidisciplinary team to perform the initial assessment and develop the waiver participant's initial waiver plan of care;

(b) Assisting the waiver participant or the parent or parents of a minor child with scheduling and attending the appointments required for the waiver initial assessment;

(c) On behalf of the waiver multidisciplinary team, providing written notification to the waiver participant or the parent or parents of a minor child of the MSDE approval of the waiver participant's waiver enrollment and the effective date of enrollment;

(d) Assuring that the waiver participant or the parent or parents of a minor child are informed and understand their rights and responsibilities related to the Autism Waiver and Medicaid;

(e) Assisting waiver participants with the waiver enrollment process specified in COMAR 10.09.56; and

(f) Assisting with completion of forms and coordinating with the Department for determination of the waiver participant's Medicaid financial and technical eligibility in a timely fashion.

5. Waiver Ongoing Service Coordination

A monthly unit of service is defined for waiver ongoing service coordination as:

(a) At least one documented monthly contact by the waiver participant's service coordinator in person, by telephone, or through written progress notes with the waiver participant or parent;

(b) A quarterly visit to the waiver participant's residence, residential program, or day program, including at least one visit to the waiver participant's residence every 12 months; and

(c) The provision of all other necessary services specified under COMAR 10.09.52.

The covered services shall include, as necessary:

(a) Acting as a central point of contact relating to a waiver participant;

(b) Coordinating Autism Waiver Service Coordination with the Department and MSDE;

(c) Referring the waiver participant to the Autism Waiver providers specified in the waiver plan of care;

(d) Assisting the waiver participant with gaining access to the Autism Waiver services preauthorized in the waiver plan of care according to the type, level, amount, frequency, duration, and cost specified;

(e) Assisting with coordination of the Autism Waiver service delivery;

(f) Providing the waiver participant and the parent or parents with information and direction to assist them with accessing and using successfully the Autism Waiver services preauthorized in the waiver plan of care;

(g) Maintaining contact with the waiver participant's waiver and other service providers and with the waiver participant or parent through documented home visits, office visits, school visits, telephone calls, mailings, and follow-up services as necessary;

(h) Following up to identify any problems or obstacles to the waiver participant's appropriate receipt of the Autism Waiver services specified in the waiver plan of care;

(i) Assisting to resolve any conflicts or crises in delivery of the waiver participant's Autism Waiver services which jeopardize the waiver participant's community placement or the health and safety of the waiver participant or another individual;

(j) Making minor changes to the waiver participant's waiver plan of care as necessary, without reconvening the waiver multidisciplinary team, if the change is approved by MSDE and the waiver participant's parent or parents;

(k) Assuring that the necessary documentation is maintained in the waiver participant's case file, as specified in COMAR 10.09.52;

(l) Providing MSDE with required information in the established time frame on waiver participants enrolled in or being terminated from the Autism Waiver; and

(m) Monitoring on an ongoing basis is defined as:

(i) The appropriateness of the type, level, amount, frequency, duration, and quality of the Autism Waiver services received by a waiver participant;

(ii) Whether a waiver participant's Autism Waiver services are delivered in an integrated and coordinated fashion and adequately meet the waiver participant's current needs; and

(iii) The impact of the Autism Waiver services on the waiver participant's health, safety, development, relationships with family members and other persons, home environment, educational program, quality of life, and life satisfaction.

6. Waiver Reassessment

A "unit of service" is defined as:

(a) A completed waiver plan of care review, with revisions as necessary, which is approved by MSDE and signed by the service coordinator, the waiver participant or the parent or parents of a minor child, and all other members of the waiver multidisciplinary team; and

(b) The provision of all other services specified under 10.09.52.

The covered services shall include:

(a) Convening, coordinating, and participating on the waiver multidisciplinary team at least every12 months to review, and revise as necessary, the waiver participant's waiver plan of care;

(b) Assisting waiver participants with the waiver's eligibility redetermination process, as specified in COMAR 10.09.56;

(c) Coordinating with the Department for redetermination of the waiver participant's Medicaid financial and technical eligibility in a timely fashion;

(d) Assisting the waiver participant or the parent or parents of a minor child with completion and submission of the application forms and accompanying documentation for the Medicaid financial and technical eligibility redetermination, before the deadline established by the Department;

(e) On behalf of the waiver multidisciplinary team, providing written notification to the waiver participant or the parent or parents of a minor child of DHMH's approval or denial of the waiver participant's continued waiver enrollment; and

(f) If continued enrollment is denied by DHMH providing written notification to the waiver participant or the parent or parents of a minor child of the effective date for the waiver participant's termination from the waiver, the reason or reasons for ineligibility, and the right to appeal and request a fair hearing under COMAR 10.01.04 and 42 CFR Part 431, Subpart E.

E. Qualifications of Providers

1. A provider of Service Coordination for Children with Disabilities shall be an agency within the State that:

a. Operates programs with special education and related services for children with disabilities, in accordance with Maryland State Department of Education regulations for Programs for Students with Disabilities (COMAR 13A.05.01); and

b. Is eligible to receive, through the Maryland State Department of Education, funding from Assistance to States for the Education of Children with Disabilities under Part B of the Individuals with Disabilities Education Act.

2. The provider shall convene an IEP team or teams which include:

a. A chairperson designated by the local superintendent of schools or other appropriate official of the agency that operates education programs for students with disabilities;

b. Individuals who are familiar with the participant's current level of functioning;

c. A special educator and interdisciplinary personnel from the agency which operates education programs for students with disabilities, the local health department, and other public agencies, as appropriate;

d. Other individuals considered appropriate, such as individuals expected to provide direct services to the participant; and

e. If the participant is suspected of having a specific learning disability, at least one person qualified to conduct individualized diagnostic examinations, such as a school psychologist or speech language pathologist, and

(1) The participant's regular teacher;

(2) If the participant does not have a regular teacher, a regular classroom teacher qualified to teach a student of that age; or

(3) An individual certified to teach a child of that age, if the child is less than school age.

3. The IEP team shall:

a. Provide the opportunity for participation in an IEP team meeting to the participant's parent(s) or other responsible individual, and the participant, if appropriate;

b. Receive referrals of recipients who are 2 through 20 years old and are identified as potentially eligible for Service Coordination for Children with Disabilities;

c. Arrange for an appropriate assessment of a recipient referred to the IEP team to determine whether the recipient has temporary or long-term special

education and related service needs arising from cognitive, emotional, or physical factors, or any combination of these;

d. Complete the assessment within 45 calendar days of the recipient's referral to the IEP team;
e. Review the results of the assessment and determine the recipient's eligibility for Service Coordination for Children with Disabilities services within 30 calendar days of assessment's completion;
f. Develop an Individualized Education Program (IEP) within 30 calendar days of the determination of the participant's eligibility for Service Coordination for Children with Disabilities;
g. Review the IEP and progress of each participant who is receiving the special education and related services recommended in the IEP, within 60 school days after the participant's initial placement in special education;
h. Meet and conduct an annual review of each participant's IEP and, if appropriate, revise the IEP's provisions; and
i. Reconvene the IEP team to conduct an interim IEP review or to modify the existing IEP at any time upon request of the professionals included on the IEP team or the participant's parent(s) or other responsible individual, as deemed necessary purusant to the participant's progress.

4. The provider shall employ specific, qualified individuals as service coordinators (i.e., case managers)for participants and verify their credentials for providing the covered services.

5. The provider shall be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs which are applicable to participants.

6. The provider shall employ qualified individuals needed to staff IEP teams, develop participants' IEPs or perform as service coordinators for participants.

7. The provider shall obtain the participant's parent's or other responsible individual's approval of the participant's service coordinator and the participant's IEP prior to implementation.

8. The provider shall maintain a file on each participant which meets the Medical Assistance Program's requirements and which includes:
   a. Copies of the participant's IEP with any revisions;
   b. Written parental consent for the provision of Service Coordination for Children with Disabilities to the participant;
   c. A record of service coordination encounters concerning the participant;

9. Service Coordinator Requirements

a. An individual chosen as a participant's service coordinator (i.e., case manager) shall be:

(1) Employed by a provider of Service Coordination for Children with Disabilities; and

(2) Chosen by the IEP team, with the approval of the participant's parent(s)or other responsible individual, taking into consideration the:

(a) Primary disability manifested by the participant;

(b) Participant's needs; and

(c) Services recommended in the IEP.

b. A service coordinator may be a nonprofessional or a professional (e.g., audiologist, guidance counselor, registered nurse, occupational therapist, physical therapist, psychologist, pupil personnel worker, social worker, speech therapist, speech pathologist, teacher, school administrator, or school supervisor).

c. A professional chosen as a service coordinator for a participant shall have a current license or certification in the profession most immediately relevant to the participant's needs.

d. A nonprofessional chosen as a service coordinator for a participant shall:

(1) Be a parent of a child with disabilities, but not of the particular participant;

(2) Have at least a high school diploma or the equivalent; and

(3) Have satisfactorily completed training in advocacy at a parent information center that is approved by the Maryland State Department of Education.

e. A service coordinator shall:

(1) Participate with the IEP team in the development or revision of a participant's IEP and in the IEP review;

(2) Assist the participant in gaining access to the services recommended in the IEP; and

(3) Collect and synthesize evaluation reports and other relevant information about a participant that might be needed by an IEP team.

A. General requirements for participation in the Program are that a provider shall meet all the conditions for participation as set forth in COMAR 10.09.36.03.

B. Specific requirements for participation in the Program as a provider of Service Coordination for Children with Disabilities are that a provider shall be an agency within the State that:

(a) Operates programs with special education and related services for children with disabilities, in accordance with Maryland State Department of Education regulations for Programs for Students with Disabilities (COMAR 13A.05.01); and

(b) Is eligible to receive, through MSDE, funding from Assistance to States for the Education of Children with Disabilities under Part B of the Individuals with Disabilities Education Act;

(1) Convene or participate on an IEP team or teams, in accordance with COMAR 13A.05.01, which shall:

(a) Include individuals from at least two disciplines as specified in COMAR 13A.05.01 and determined by the participant's disability, and provide the opportunity for participation to the participant's parent or parents, and the participant, if appropriate, pursuant to COMAR 13A.05.01;

(b) Receive referrals of recipients who are 2 through 20 years old, or who are waiver participants, and are identified as potentially eligible for the services covered under this chapter;

(c) Conduct an assessment of a recipient within 90 days of receiving a written referral;

(d) Develop an IEP for a participant in accordance with COMAR 13A.05.01 within 30 calendar days of the determination of eligibility for the services covered under this chapter;

(e) Review the IEP and progress of each participant who is receiving the special education and related services recommended in the IEP, upon request of the parent or parents;

(f) Meet and conduct an annual review of each participant's IEP and, if appropriate, revise the IEPs provisions, and

(g) Reconvene the IEP team to conduct an interim IEP review and modify the existing IEP at any time upon request of the professionals included on the team or the parent or parents, as considered necessary pursuant to the participant's progress;

(2) Designate specific, qualified individuals as service coordinators, and verify their credentials for providing the services covered under this chapter;

(3) Be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs which are applicable to participants;

(4) Maintain a file on each participant which meets the Program's requirements and which shall include:

(a) Copies of the participant's IEP with any revisions,

(b) Written parental consent for the services covered under this chapter,

(c) A record of service coordination encounters concerning the participant,

(d) Approval from a participant's parent of the participant's service coordinator and the participant's IEP before implementation of the service coordination, and

(e) The following documentation for a waiver participant:

(i) Diagnosis of autism;

(ii) Form for determination of eligibility for level of care in an intermediate care facility for the mentally retarded and persons with related conditions (ICF-MR)—initial determination and redetermination, at least annually;

(iii) Consent form for autism waiver services, signed before Autism Waiver enrollment;

(iv) Form for determination of Medicaid eligibility for autism waiver services—initial determination and redetermination, at least annually;

(v) Waiver plan of care—initial plan, review at least annually, and any plan revisions;

(vi) Preauthorization by MSDE of any environmental accessibility adaptations reimbursed through the Autism Waiver; and

(vii) The waiver participant's IEP developed in accordance with this chapter or individualized family service plan (IFSP) developed in accordance with COMAR 10.09.40;

(5) Employ or have under contract qualified personnel who convene or participate on IEP teams, convene or participate on waiver multidisciplinary teams as

necessary, develop participants' IEPs, or waiver plans of care, and perform as service coordinators for participants; and

(6) Convene or participate on a waiver multidisciplinary team or teams for waiver participants, in accordance with the requirements of COMAR 10.09.56 and this chapter.

Enclosure 31

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1915(j)

X Self-Directed Personal Assistance Services, as described and limited in Supplement 11 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

Enclosure 31

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1915(j)

X Self-Directed Personal Assistance Services, as described and limited in Supplement 11 to Attachment 3.1-B.

ATTACHMENT 3.1-B identifies the medical and remedial services provided to each covered group of the medically needy.

Enclosure 31

Attachment 3.1-A

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

__**X**___Self-Directed Personal Assistance Services, as described in Supplement 11 to Attachment 3.1-A.

_**X**___Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

_____No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

Enclosure 31

Attachment 3.1-B

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Medically Needy

__**X**___Self-Directed Personal Assistance Services, as described in Supplement 11 to Attachment 3.1-B.

X Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

_____No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

Enclosure 31

Supplement 11 to Attachment 3.1-A and 3.1-B

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. **X** In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 23 of the Medicaid State Plan.

B. _____ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. **X** State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

B. _____ Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

_____

_____

_____

_____

iii. Payment Methodology

A. _____ The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

B. __X__ The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

A. _____ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. __X__ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

Community Personal Assistance Services (CPAS) participants may choose to change their service delivery model at any time. Effective October 1, 2023, new applicants to the CPAS program may also elect to self-direct services by indicating this selection on the provisional or initial plan of service (POS), which is submitted by the applicant's assigned supports planner (i.e., case manager). A POS is developed by a supports planner in conjunction with the applicant or participant through a person-centered planning process. To transition between the self-directed and traditional service delivery models (i.e., agency model), participants are required to notify their assigned supports planner. Supports planners facilitate and coordinate the necessary changes within the Department's data management system, including assignment to, or unassignment from, as applicable, a Financial Management and Counseling Services (FMCS) contractor. A change in service delivery model will require a revised POS, or if the change is elected during the annual redetermination process, an annual POS, which indicates the participant's choice of an FMCS contractor or a Medicaid-enrolled agency provider, as applicable. The participant's assigned supports planner is responsible for developing the POS, in conjunction with the participant (or representative, as applicable), and submitting it to the Department,

or its designee, for review within 30 days of the participant's decision to change service delivery models. Developing the POS includes assisting a participant in selecting an agency provider if transitioning from the self-directed model to the agency model. Supports planners provide participants with a list of all Medicaid-enrolled agency providers serving their jurisdiction, and will facilitate the selection process by outreaching to selected providers and obtaining necessary signatures. Conversely, if the participant is transitioning from the self-directed model to the agency model, the supports planner will provide a list of available FMCS contractors, and facilitate the selection process as described above. The approved plan will remain active and participants will continue to receive services under their current service delivery model until a revised POS is approved.

The Department, or its designee, is responsible for reviewing and approving the revised plan. Once the POS has been approved, the participant will be able to access services through the service delivery model of choice. Should the transition be urgent in nature, the Department's data management system allows for a POS to be sent as an urgent request. Upon approval of the POS, the participant's supports planner is responsible for coordinating the transition between service delivery models to ensure continuity of services with the effective date of the approved POS as determined by the Department or its designee.

In addition to a supports planner, individuals choosing to self-direct services will be supported by a Medicaid-enrolled FMCS contractor. The FMCS contractors will assist self-directing participants with enrollment in the self-directed model, as well as transitions to the agency model as it pertains to the termination of self-directed services and a participant's responsibilities as an employer.

While a participant may choose to voluntarily disenroll from the self-directed model at any time, there may be circumstances in which a participant's disenrollment is involuntary. In these instances, the Department, its supports planners, and/or its FMCS contractors will be required to provide additional counseling to the participant prior to disenrollment from the self-directed model.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below.

A participant may be involuntarily disenrolled from self-directing if the Department determines that there are concerns with respect to the participant's health and welfare or the participant violates state or federal regulations or program policy. Prior to the participant's disenrollment from the self-directed model, the Department, its supports planners, and/or its FMCS contractors will be required to provide the participant with

additional counseling. Concerns surrounding a participant's health and welfare, or violations of any state or federal regulations or program policies, will be documented and reported by way of the Department's incident management system, which is embedded in its data management system.

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

As noted above, a participant's assigned supports planner facilitates and coordinates the necessary changes within the Department's data management system, including assignment to, or unassignment from, as applicable, an FMCS contractor. A change in service delivery model requires a revised POS, which will indicate the participant's choice of an FMCS contractor or a Medicaid-enrolled agency provider, as applicable.

The participant's assigned supports planner is responsible for developing the revised POS, in conjunction with the participant (or representative, as applicable), and submitting it to the Department, or its designee, for review within 30 days of the determination regarding the need to change service delivery models. The Department, or its designee, is responsible for reviewing and approving the revised POS. Should the transition be urgent in nature, the Department's data management system allows for a POS to be sent as an urgent request. Upon approval of the POS, the participant's supports planner is responsible for coordinating the transition between service delivery models to ensure continuity of services with the effective date of the approved POS as determined by the Department or its designee. Participants will continue to receive services under their current service delivery model until the revised POS is approved by the Department or its designee.

As also noted above, the FMCS contractors are responsible for supporting self-directing participants, including in the context of a transition in service delivery models.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

CPAS participants, if not in their own homes, must reside in a setting that is integrated in, and supports full access to, the community. The setting must be chosen by the individual or the individual's representative, from among all available setting options. This is inclusive of non-disability specific settings and options for a private unit in a residential setting, and ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint are met.

viii. Geographic Limitations and Comparability

A. __X__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:

C. __X__ The State elects to provide self-directed personal assistance services to all eligible populations.

D. _____ The State elects to provide self-directed personal assistance services to targeted populations. Please describe:

E. __X__ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _____ The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:
   i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
   ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
   iii. May require self-directed personal assistance services; or
   iv. May be eligible for self-directed personal assistance services.

D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting

the following criteria:

i. Appropriately assesses and counsels individuals prior to enrollment;
ii. Provides appropriate counseling, information, training, and assistance to ensure that participants are able to manage their services and budgets;
iii. Offers additional counseling, information, training, or assistance, including financial management services:
    1. At the request of the participant for any reason; or
    2. When the State has determined the participant is not effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every 3 years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of section 1902(a)(27) of the Social Security Act, and Federal regulations 42 CFR 431.107, governing provider agreements, are met.

I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:

i. Objective and evidence based, utilizing valid, reliable cost data.
ii. Applied consistently to participants.
iii. Open for public inspection.
iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.
viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.
ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Case management providers, known as Supports Planning Agencies (SPAs), are responsible for developing participants' service plans, in conjunction with participants (or their representatives, as applicable), through a person-centered planning process. The assigned supports planner submits the service plan to the Department or its designee for review and approval. This process is the same regardless of whether the participant elects the agency or self-directed model. SPAs are required by state and federal regulations, as well as program policy, to be free from conflicts of interest. Conflicts of interest are defined as any real or seeming incompatibility between one's private interests and one's public or fiduciary duties. All Medicaid-enrolled providers, including SPAs, are required to ensure freedom of choice among any willing provider. The Department provides program applicants a packet of materials that include brochures from all available SPAs in their service area.

All SPAs must submit reports on conflict monitoring and remediation efforts to the Department on a quarterly basis. SPAs must also audit their own case management activities and submit the results of their audit to the Deparment on a weekly basis. To further ensure that conflicts of interest do not occur, the standardized assessment of need, which informs the person-centered planning process, is completed by the Local Health Departments (LHDs) or the Department's Utilization Control Agent (UCA).

For self-directing participants, the FMCS contractors are responsible for reviewing and approving service plans, but have no role in the development of, or subsequent revisions to, the plan, which is the sole responsibility of the participant's assigned supports planner.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

CPAS will adopt the Quality Improvement Strategy utilized in its 1915(c) Home and Community-Based Options Waiver (HCBOW) and 1915(k) Community First Choice (CFC) programs, where appropriate. This Quality Improvement Strategy is designed

to continuously review operations and when issues are discovered, remediate those issues and implement quality improvement activities to prevent the repeat of operational problems. The State Medicaid Agency (SMA) oversees a cross-agency quality committee called the Home and Community-Based Services (HCBS) Council. The HCBS Council meets regularly to address operational issues through data analyses, share program experiences and information, and further refine the Quality Improvement Strategy.

The Office of Long Term Services and Supports (OLTSS), within the SMA, is the lead entity responsible for trending, prioritizing, and implementing system improvements; as such, the OLTSS collects, aggregates, and analyzes data in support of this. While most of these data are maintained in the Department's data management system and the Medicaid Management Information System, the OLTSS also collects and aggregates data outside of these systems; for example, through ongoing provider audits. The OLTSS utilizes a combination of reports built into the Department's data management system and custom reports to extract and aggregate data. Most data analysis conducted by the OLTSS is quantitative, rather than qualitative, and most often seeks to evaluate the delivery and quality of CPAS services and supports.

Partners in the Quality Improvement Strategy include, but are not limited to the Office of Health Care Quality, providers, participants, participants' families, the Community Options Advisory Council, which is a participant-majority advisory group, and the HCBS Council. The SMA may convene a specific task group to address significant problem areas, which will include stakeholders from the partners identified above.

In accordance with the Department's Reportable Events Policy, all entities associated with the CPAS program are required to report alleged or actual adverse incidents that occurred with participants. All reportable events for CPAS participants are analyzed by the OLTSS to identify trends related to areas in need of improvement. Any person who believes that a participant has experienced abuse, neglect, or exploitation is required to immediately report the alleged abuse, neglect, or exploitation to law enforcement and Adult or Child Protective Services, as appropriate. The event report must be submitted to the OLTSS within one (1) business day of knowledge or discovery of the incident.

The OLTSS, or its designee, monitors provider settings and service delivery through a variety of activities, including reviews of provider data, POS, reportable events noting alleged or actual adverse incidents that occurred with participants, and conducting on-site visits to sites. The Department utilizes the Community Settings Questionnaire (CSQ) to determine whether an applicant/participant's setting is compliant. An applicant/participant's supports planner completes a CSQ with the applicant/participant and/or the applicant/participant's identified representative, if applicable, during the initial and annual plan processes, and upon any change in the participant's residence. The OLTSS reviews all CSQ to determine if the

applicant/participant resides in a compliant setting, and will review aggregated CSQ data, as needed, to ensure continual compliance.

ii. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

1. Performance Measures:
    a. As noted, the Department will adopt the Quality Improvement Strategy utilized in its 1915(c) HCBOW and 1915(k) CFC programs, where appropriate, including collecting and analyzing data on CPAS participants, services, and supports for all performance measures that are included in the approved 1915(c) HCBOW application. Current performance measures seek to evaluate the timeliness of level of care determinations and the person-centered planning process, the effectiveness of the person-centered planning process in meeting participants' needs, maintenance of provider qualifications, effectiveness of the incident management system in assuring participants' health and welfare, and fiscal integrity. The Department will review these data quarterly to identify opportunities for continuous quality improvement.
    b. In addition to the performance measures outlined in the 1915(c) HCBOW application, the Department will evaluate performance through reports built into the Department's data management system and custom reports on assessments, supports planning, POS, and reportable events.
2. Outcome Measures:
    a. The Department is able to track participants' health and functional status over time using the standardized assessment of need and analyze data by service type and key demographics. The Department intends to use these data to evaluate the degree to which the receipt of CPAS services and supports is positively correlated with improvements in health outcomes over time.
3. Satisfaction Measures:
    a. The Department currently utilizes the Money Follows the Person Quality of Life Survey, amended with several questions from the Participant Experience Survey to evaluate participants' satisfaction with the CPAS program. The Department or its designee analyze the results of the surveys and use the results to inform programmatic changes. The Department will perform these surveys internally with a random sample of participants until such time as the Department is able to secure a contractor through a procurement process.
    b. For self-directing participants, the FMCS contractors are

required to develop and conduct a Quality Satisfaction Survey with a random sample of 10% of participants to whom they are assigned. The Department will review the FMCS contractors' surveys as part of its review of the contractors' quality plans. The results of the satisfaction survey will be reported to the Department on a quarterly basis and also include an evaluation of the accuracy and timeliness of reporting for self-directing participants' employees. The Department will work with the FMCS contractors to use results from the surveys to inform changes.

xii. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

The Department identifies potential risks to participants through the standardized assessment of need, the person-centered planning process, ongoing engagement by way of supports planning and nursing monitoring (for participants receiving PAS), and its incident management system. The Department also requires Medicaid-enrolled providers to meet and maintain certain qualifications, which may include licensure and/or certifications, as well as completing background checks on their employees prior to hire.

The standardized assessment of need (currently the interRAI assessment) is conducted by the LHDs or the Department's UCA and evaluates the needs, strengths, and preferences of individuals in home and community-based settings. The assessment focuses on individuals' functioning and quality of life and is currently used to inform and guide comprehensive planning of care and services. The assessment identifies where individuals could benefit from further evaluation of specific problems or risks for functional decline. These items, known as "triggers," link the assessment to a series of problem-oriented Clinical Assessment Protocols (CAPs). Generally, the assessment takes place at an applicant/participant's residence, which also allows the assessor to evaluate potential risk factors associated with the applicant/participant's environment.

The LHD or the Department's UCA conducts the standardized assessment of need upon initial application to the program, annually, and upon a significant change in health or functional status. After completing the assessment, the assessor develops a recommended plan of care (POC) outlining the services and supports that will meet the applicant/participant's assessed needs in the community, enable them to avoid institutionalization, and remain as independent as possible in the least restrictive environment.

As discussed in more detail below, supports planners use a person-centered planning process to help applicants/participants (or their representatives, as applicable) identify risks as well as resources to mitigate those risks, including selection of an emergency

back-up provider regardless of service delivery model. Upon review of the POS, the Department or its designee, may return a plan to the applicant/participant's assigned supports planner if the individual's health and welfare is not adequately addressed by

the plan, and as a last resort, may deny a request for services if the applicant/participant's needs cannot be appropriately supported in the community with available services.

Supports planners meet with participants at least once every 90 days to monitor implementation of participants' POS and identify any unmet needs. Participants who choose to waive these minimum contact standards may identify unmet needs via a consumer portal in the Department's data management system. Supports planners are required to inquire about any changes in health and functional status, as well as unmet need during quarterly contacts. Based on the interaction, a supports planner may request a significant change assessment from the LHD, submit a revised POS to request a change in services and supports, and/or submit a reportable event through the Department's incident management system, which is embedded in its data management system.

Participants in the self-directed model are also required to complete a background check on any individual they intend to employ, prior to hire, but have the right to waive any further action based on the results of the background check unless the results indicate a history of behavior that could be harmful to participants.

For self-directing participants, the FMCS contractor is also responsible for identifying and mitigating risks associated with a participant's self-direction of services, including the participant's management of his/her employees and his/her budget, which includes over or underutilization.

B. The tools or instruments used to mitigate identified risks are described below.

Each applicant/participant's POS is required to include all identified risks, as well as a method to address those risks through a variety of Medicaid and non-Medicaid services and supports. Supports planners use a person-centered planning process to help applicants/participants (or their representatives, as applicable) identify resources to mitigate risks. The following strategies to mitigate risk are incorporated into the applicant/participant's plan and the person-centered planning process more broadly:

i. Utilizing the standardized assessment of need and recommended POC to assist in the development of the POS.
ii. Recommending an evaluation of the applicant/participant's home to identify environmental factors posing potential risk.
iii. Recommending consultation by a licensed behavioral health specialist to identify behavioral health factors posing potential risk.
iv. Recommending consultation by a licensed dietitian or nutritionist to identify nutritional factors posing potential risk.
v. Utilizing the recommendations from the environmental, behavioral, and/or nutritional assessments to inform the POS.
vi. Identifying an emergency back-up plan for PAS, regardless of service delivery model.
vi. Recommending a change in services because of a change in the participant's health, functional status, and/or environment.
vii. Informing the participant of the possible consequences of refusing services, including disenrollment from the program.

As noted previously, the Department also monitors providers and service delivery through reviews of provider data, POS, reportable events noting alleged or actual adverse incidents that occurred with participants, and on-site visits.

The SMA became compliant with the Electronic Visit Verification System (EVV) requirements for Personal Care Services (PCS) on January 1, 2014 in accordance with section 12006 of the 21st Century CURES Act.Employees of participants in the self-directed model utilize the FMCS contractors' systems to enter time worked and the participant is responsible, with support from the FMCS, for ensuring the accuracy of time entered in conjunction with payment authorization. Effective July 1, 2023, personal assistance providers residing with participants to whom they are providing services may be exempted from the EVV requirement in accordance with COMAR 10.09.36.03B(2)(c)(ii)-(d).

For self-directing participants, the FMCS contractors are also responsible for identifying trends in service utilization or patterns of behavior that could pose a risk to participants and reporting them to the Department. The FMCS contractors must submit a Quality Assurance Monitoring Plan to the Department describing their ongoing monitoring efforts and strategies for remediating issues identified for the self-directing participants to whom they are assigned.

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

As noted above, the person-centered planning process includes risk identification and mitigation through discussion and negotiation among the applicant/participant (or representative, if applicable) and the assigned supports planner. All POS are reviewed and approved by the Department, or its designee, prior to implementation of services. In addition to a specific section of the POS that identifies risks, the CAPs from the standardized assessment of need are auto-populated in the plan. Each POS requires the inclusion of an emergency back-up and an indication by the supports planner submitting the POS that the plan meets the applicant/participant's needs with respect to health and welfare.

If there is insufficient information in the plan to determine if risks have been

appropriately identified and mitigated to the extent possible, the Department, or its designee, will request additional information before rendering a final decision. All plans are required to meet the needs of the applicant/participant with respect to health and welfare prior to approval. If a risk cannot be mitigated, the applicant/participant is informed of the possible consequences of refusing services, including, as applicable, inability to enroll in, or disenrollment from, the program. The applicant/ participant's choice is fully documented in the Department's data management system.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

Supports planners are trained on the person-centered planning process for the development of all service plans, which occur, at minimum during initial enrollment and during the annual redetermination process. Supports planners are required to assist applicants/participants with accessing Medicaid and non-Medicaid services and supports, which includes discussion about the freedom to select from any willing provider, to choose from the agency or self-directed service delivery models, and to exert as much choice and control over their services as possible regardless of service delivery model. The applicant/participant (or representative, if applicable), must sign the POS to indicate agreement with all information documented within the plan. This is inclusive of the risks identified and the services and supports put in place to support the individual and to mitigate those risks.

xiii. Qualifications of Providers of Personal Assistance

A. ____ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

B. __**X**__ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

xiv. Use of a Representative

A. __**X**__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i. ____The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

B. ____ The State elects not to permit participants to appoint a representative

to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

A. ____ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

B. __**X**__ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. **X** The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. ___ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. **X** The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48).

iii. ___ The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. _____ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.