Table of Contents

State/Territory Name: Maryland

State Plan Amendment (SPA) #: 18-0002

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

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

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

SWIFT #022620184025

March 14, 2018

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

Dear Mr. Schrader:

Enclosed is a copy of the approved State Plan Amendment (SPA), Transmittal Number 18-0002. The purpose of this SPA is to update web links to the Department's new provider web page, as well as change any references to the Department's old name.

The effective date for this amendment is January 1, 2018. The CMS 179 form and the Approved State Plan pages are attached.

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

Sincerely,
/s/

Francis T. McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18-0002

2. STATE: Maryland

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

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

4. PROPOSED EFFECTIVE DATE: January 1st, 2018

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: N/A

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

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19B pgs: 4a. 5. 6 B-1. 6B-2. 8. 10. 12. 13. 14. 15. 15A. 16. 16A. 17-23. 31. 32-B. 34. 36. 37. 37-A. 38. 38-B. 38-C. 39. 41A. 51. 56. 58. 60. 61. 63. 65. 67 (AMEND)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Att. 4.19B pgs:

- 6 B-1 & 6B-2 (13-03)
- 34 (14-08)
- 8 (15-0008)
- 31 & 38(15-0012)
- 5. 10 & 12 (15-0014)
- 4a ,13. 14. 15. 15A. 16. 16A. 18-23. 32-B. 36. 36-A. 37. 37-A. 38-B. 38-C. 39. 41A. 56. 58. 60. 61. 63. 65. 67(16-0007)
- 17 (16-0010)
- 39. 41A. 51 (16-0012)

10. SUBJECT OF AMENDMENT: To clean-up web links and update Department name

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/

13. TYPED NAME: Dennis Schrader

14. TITLE: Medicaid Director, Maryland Department of Health

15. DATE SUBMITTED: February 26, 2018

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: February 26, 2018

18. DATE APPROVED: March 14, 2018

PLAN APPROVED ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2018

20. /s/

21. TYPED NAME: Francis T. McCullough

22. TITLE: Associate Regional Administrator

23. REMARKS: The state permits CMS to make a pen and ink change to SPA 18-0002 form 179 with the submission date of February 26, 2018.

OVERHEAD

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

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

1. Effective July 1, 2009, the service will be covered using the provide code T1029 –On-site Environmental Lead Inspection, per primary dwelling – at a rate of $333.29. Subsequently, the rate will increase by 2% annually. This rate is published on the Maryland Department of Health website at:

   health.maryland.gov/providerinfo

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Physician and Osteopath Rates

5.a All providers described in 5.b, both government and non-government, are reimbursed pursuant to the same fee schedule. Providers are paid by CPT codes which are based on a percentage of Medicare reimbursement. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 were set at 100 percent using rates from the March 2013 Deloitt release, an agency contracted by CMS to determine the rates.

5.b The Department's original reimbursement methodology for professional services rendered by a physician or osteopath was set July 1st, 2015 and is effective for services rendered on or after that date. All providers must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. Providers will be paid the lower of either the provider's customary fee schedule to the general public or the published Medicaid fee schedule. The average Maryland Medicaid payment rate is approximately 79.5 percent of 2017 Medicare fees. In addition, the State will pay the federally calculated VFC administration charge. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

5.c Professional services rendered by physicians to a trauma patient on the State Trauma Registry, who is receiving emergency room or inpatient services in a state designated trauma center, reimbursement will be 100 percent of the Baltimore City and surrounding area Title XVIII Medicare physician fee schedule facility fee rate. All providers must be licensed in the jurisdiction in which they provide services and must be providing services within a state designated trauma center. Services are limited to those outlined in 3.1A of the Maryland State Plan. The provider will be paid the lower of either the provider's customary fee schedule to the general public or the fee methodology described above.

See Attached page 4.19B Page 6B-3

(Primary Care Services Affected by the Payment Methodology – continued)

☒ The State will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added)

See Attached page 4.19B Page 6B-3

Physician Services – Vaccine Administration

For calendars years (CYs) 2013 and 2014 the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400 (a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State Regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 9047.

☐ The inputed rates in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____________.

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code.

The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

☒ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09: Maryland only pays a separate administration fee for VFC vaccines. It is our position that the provider is paid for non VFC vaccine administration through the appropriate office medical visit. Attached is a crosswalk of the appropriate VFC product codes (Attachment 4.19B: page 6B-4).

Note: The above section contains a description of the state's methodology and specifics the affected billing codes.

Effective Date of Payment

E&M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 48 hours per response, including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Physician Assistant Rates

8.a The Department's original reimbursement methodology for professional services rendered by physician assistants was developed as of July 1, 2015 and is effective for services rendered on or after that date. All physician assistants must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their scope of practice in Maryland. The physician assistant will be paid the lower of either the provider's customary fee schedule to the general public or the published Medicaid fee schedule.

8.b Both government and non-government physician assistants are reimbursed pursuant to the same fee schedule. All physician assistants are paid using CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 79.5 percent of 2017 Medicare fees. In addition, the state will pay the federally calculated VFC administration charge. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

8.c Payment limitations:

- The Department will not pay for physician assistant administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay a provider for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedure directly.
- The provider may not bill the Program or the recipient for:
    - Completion of forms and reports;
    - Broken or missed appointments;
    - Professional services rendered by mail or telephone; and
    - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Podiatrist Rates

8.a All podiatrists, both government and non-government are reimbursed pursuant to the same fee schedule. Podiatrists are paid by CPT codes which are based on a percentage of Medicare reimbursement. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 were set at 100 percent using rates from the March 2013 Deloitt release, an agency contracted by CMS to determine the rates.

8.b The Department's reimbursement methodology for professional services rendered by a podiatrist was developed as of July 1, 2015 and is effective for services rendered on and after that date. All podiatrists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The podiatrist will be paid the lower of either the podiatrist's customary fee schedule to the general public or the published fee schedule. The average Maryland Medicaid payment rate is approximately 79.5 percent of Medicare 2017 fees. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

8.c Payment limitations:

- Preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them as consultations.
- Referrals from one podiatrist to another for treatment of specific patient problems may not be billed as consultations.
- The operating podiatrist may not bill for the administration of anesthesia or for an assistant podiatrist who is not in his employ.
- Payment for consultations provided in a multi-specialty setting is limited by criteria established by the Department.
- The Department will not pay a podiatrist for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedure directly.
- The Department will not pay for provider-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay for services which do not involve direct, face-to- face, patient contact.
- The provider may not bill the Program or the recipient for:
    - Completion of forms and reports;
    - Broken or missed appointments;
    - Professional services rendered by mail or telephone;
    - Services which are provided at no charge to the general public; and
    - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

Physical Therapist Rates

9.a The Department's reimbursement methodology for professional services rendered by a physical therapist was set as of July 1, 2017 and is effective for services rendered on or after that date. All physical therapists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The physical therapist will be paid the lower of either the physical therapist's customary fee schedule to the general public or the published Medicaid fee schedule.

9.b All physical therapists, both government and non-government, are reimbursed pursuant to the same fee schedule. Physical therapists are paid using CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 72.5 percent of Medicare 2017 fees. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

9.c The Department reimburses schools for physical therapy evaluations, re-evaluations, and individual physical therapy sessions when required under an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) and when provided by physical therapists that are licensed in the jurisdiction in which they provide services. For all dates beginning January 1, 2010, the State will reimburse for these services at the same rates that it reimburses all other non-governmental community-based licensed physical therapists as described in 9b.

9.d Payment limitations:

- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay for services which do not involved direct, face to-face, patient contact.
- The provider may not bill the Program or the recipient for:
  - Completion of forms and reports;
  - Broken or missed appointments;
  - Professional services rendered by mail or telephone;
  - Services which are provided at no charge to the general public; and
  - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

STATE PLAN UNDER TITLE XIXI OF THE SOCIAL SECRITY ACT

State of Maryland

10. **Dentist Rates**

10.a The Department's reimbursement methodology for professional services rendered by a dentist and outlined per Attachment 3.1, page 23, was set as of January 1st, 2015 and is effective for services on or after that date. All dentists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The dentist will be paid the lower of the dentist's customary fee schedule to the general public unless it is free to individuals not covered by Medicaid or the published fee schedule.

10.b. All dentists, both government and non-government, are reimbursed pursuant to the same fee schedule. Dentists are paid by CDT codes. Effective as of January 1st, 2015, the current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

10.c. Payment limitations:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Optometrist Rates

11.a The Department's reimbursement methodology for professional services rendered by an optometrist were set as of July 1st, 2010 and is effective for services on or after that date. All optometrists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The optometrist will be paid the lower of the optometrist's customary fee schedule unless it is free to individuals not covered by Medicaid or the published fee schedule.

11.b All optometrists, both government and non-government, are reimbursed pursuant to the same fee schedule. Optometrists are paid based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

11.c Payment limitations:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

4. Reimbursement Methodology for Mental Health Case Management

4.a Effective September 1st, 2009, payments shall be made with the fee-for-service schedule for mental health case management services specified in 4c. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

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

4a. Effective, October 1, 2014, payment shall be made with the fee-for-service schedule mental health care management services specified in 4c. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Mental Health Case Management

The Department's reimbursement methodology for Mental Health Case Management was set as of July 1st, 2013 and is effective for services on or after that date. Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both governmental and private providers.

Updated rates are included on the current fee schedule which is published on the Department's website at:

health.maryland.gov/providerinfo

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Reimbursement Methodology for HIV Targeted Case Management Services

1. 1. The reimbursement methodology was set on February 1, 2012 and is effective for services on or after that date. HIV targeted case management, including diagnostic evaluation services (DES) and ongoing case management services are paid as outlined in MD fee-for-service schedule. Except as otherwise noted in the Plan, state developed fee schedule rates are the same for both government and nongovernmental and private individual practitioners. The current fee schedule is published on the Department's website at:

   health.maryland.gov/providerinfo

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community-Based Substance Use Disorder Services

Reimbursement Methodology

1.

A. The Department's reimbursement methodology for community-based substance use disorder services is fixed rates. It was set as of April 4th, 2017 is effective for services on or after that date. All providers must be certified by the Office of Health Care Quality and shall meet the requirements established by the Department. Services are limited to those outlined in 3.l.A Section 13d.V of the Maryland State Plan. Providers will be paid the lower of the provider's customary fee schedule to the general public or the published fee schedule.

B. All providers described in 1a, both government and non-government, are reimbursed pursuant to the same fee schedule. Providers are paid by HCPCS codes and the rates are based on the rate that Maryland Medicaid reimburses its specialty mental health providers for similar services. These rates are below those allowed for similar codes under the Medicare Program. Updated rates are included in the current fee schedule which is published on the Department's website at:

health.maryland.gov/providerinfo

C. For dates of services January 1st, 2015 to March 6th, 2015, Level 2.5 Partial Hospitalization for individuals with a substance use disorder shall include a minimum of 2 hours per diem at a rate of $130 per diem billed up to 7 days per week. For dates of service on or after March 7th, 2015, Partial Hospitalization services shall have a minimum duration of 2 hours per diem for a half day session and a minimum of 6 hours per diem for a full day session, with up to 7 days of treatment per week. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

D. Payment limitations. The provider may not bill the Program or the participant for:
   a. Completion of forms and reports;
   b. Broken or missed appointments;

State of Maryland

Nutritionist Rates

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

12.b. All nutritionists, both government and non-government, are reimbursed pursuant to the same fee schedule. Nutritionists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

12.d. Payment limitations:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Occupational Therapist Rates

13.a The Department's reimbursement methodology for professional services rendered by an occupational therapist was set as of July 1st, 2010 and is effective for services on or after that date. All occupational therapists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The occupational therapist will be paid the lower of the occupational therapist's customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.

13.b All occupational therapists, both government and non-government, are reimbursed pursuant to the same fee schedule. Occupational therapists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

13.d Payment limitations:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Speech Therapist Rates

14.a The Department's reimbursement methodology for professional services rendered by a speech-language pathologist was set as of July 1st, 2010 and is effective for dates of services on or after that date. All speech-language pathologists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The speech-language pathologist will be paid the lower of the speech-language pathologist's customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.

14.b All speech-language pathologists, both government and nongovernment, are reimbursed pursuant to the same fee schedule. Speech-language pathologists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

14.d Payment limitations:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Audiologist Rates

15.a The Department's reimbursement methodology for professional services rendered by an audiologist was set as of July 1st, 2017 and is effective for dates of services on or after that date. All audiologists must be licensed in the jurisdiction in which they provide services. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The audiologist will be paid the lower of the audiologists customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.

15.b All audiologists, both government and nongovernment, are reimbursed pursuant to the same fee schedule. Audiologists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

15.d Payment limitations:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

16. Therapeutic Behavioral Aide Rates

16.a The Department's reimbursement methodology for one-on-one therapeutic behavioral aide services performed by therapeutic behavioral aides was set as of January 1st, 2010 and is effective for services on or after that date. Services and provider qualifications are limited to those outlined in 3.1A of the Maryland State Plan. The therapeutic behavioral aide will be paid the lower of the therapeutic behavioral aide's customary fee schedule to the general public unless the service is free to individuals not covered by Medicaid or the published fee schedule.

16.b All therapeutic behavioral aides, both government and nongovernment, are reimbursed pursuant to the same fee schedule. Therapeutic behavioral aides are paid a fixed amount per each 15 minute increments. The current fee schedule is published on the Department's website within the Behavioral Health Administrative Service Organization:

health.maryland.gov/providerinfo

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

16.d Payment limitations:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

17. EPSDT – Private Duty Nursing and Other Licensed Practitioners

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

health.maryland.gov/providerinfo

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

17.c Payment limitations:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Ambulatory Surgery Rates

A. Reimbursement Methodology:
   1) Reimbursement fees equal 80 percent of the Medicare-approved ASC facility fee for services other than dental services furnished to Medicaid recipients in connection with covered surgical procedures.
   2) The facility fee for dental services performed in a Medicare-approved ASC is reimbursed in accordance with the current fee schedule published on the Department's website at:

   health.maryland.gov/providerinfo

   3) If one covered surgical procedure is furnished to a recipient, payment is at the Maryland Medicaid Program payment amount which is 80 percent of the Medicare approved facility fee for that procedure.
   4) If more than one covered surgical procedure is provided to a recipient in a single operative session, payment is made at 100 percent of the Maryland Medicaid Program payment amount for the procedure with the highest reimbursement rate. Other covered surgical procedures furnished in the same session are reimbursed at 50 percent of the Maryland Medicaid Program payment amount for each of those procedures.
   5) When a covered surgical procedure is terminated before the completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicaid Program payment amount is based on one of the following:
      a. If the procedure for which the anesthesia is planned is discontinued after the induction of anesthesia or after the procedure is started; the reimbursement amount is 80 percent of the Medicare approved facility fee;
      b. If the procedure for which anesthesia is planned is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed, but before the anesthesia is induced; the reimbursement amount is 50 percent of the Medicare approved facility fee; or
      c. If a covered surgical procedure for which anesthesia was not planned is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed; the reimbursement is 50 percent of the Medicare approved facility fee.
   6) Practitioners bill directly for services in accordance with the Physicians Fee Schedule and the Dental Fee Schedule. The current fee schedule is published on the Department’s website at:

   health.maryland.gov/providerinfo

B. Reimbursement by the Program is for facility services provided by a free-standing ambulatory surgical center in connection with covered surgical procedures, include but are not limited to:
   1) Nursing, technician, and related services;
   2) Use of the facility;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Specific Payment Procedures for Urgent Care Centers

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

B. In addition to the facility fee, the Program shall reimburse for services rendered by the physician during the visit at the free-standing urgent care center when performed by a physician, or by other authorized personnel under that physician's supervision. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

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

D. The Program makes no direct payments to recipients.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

28. Freestanding Birth Centers: Reimbursement

Licensed or Otherwise State-Approved Freestanding Birthing Centers

Freestanding birthing centers are reimbursed a facility fee. The birthing center facility fee is consistent across birthing centers. The reimbursement methodology was set on September 1st, 2014. Physicians and Certified Nurse Midwives providing services in the freestanding birthing centers are reimbursed as previously referenced in Attachment 4.19B in the State plan under Physician Services section and Certified Nurse Midwives Services section. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of birthing center services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Department's website using the link provided above.

Disposable Medical Supplies and Durable Medical Equipment

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

The Department does not pay for:

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

The Department developed the reimbursement methodology on July 1st, 2012 and it is the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

Oxygen and Related Respiratory Equipment

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

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

The Department does not pay for:

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

The Department developed the reimbursement methodology on July 1st, 2012 and it is the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Attachment 3.1A Item 12D: Eyeglasses

The reimbursement methodology was set July 1st, 2011 is the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

The Department does not pay for:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

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

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

The reimbursement methodology was set on July 1st, 2012 and is the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

The Department does not pay for:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

3. Other Lab and X-ray Services: X-ray Services

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

The reimbursement methodology was set on July 1st, 2012 and is the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

The Department does not pay for:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Local Health Departments and General Clinics

The reimbursement methodology was set January 1st, 2012 and is effective for Local Health Departments.

A unit of service is a visit or procedure as defined in the American Medical Association Current Procedural Terminology (AMA CPT). In addition, the State will pay the federally calculated VFC vaccine administration charge. Rates are the same for both governmental and private individual practitioners and are reimbursed based on the current fee schedule published on the Department's website at:

health.maryland.gov/providerinfo

Dentists are reimbursed according to the dental fee schedule referenced on Att. 4.19B page 13.

The Department does not pay for:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Family Planning Clinics

The state-developed reimbursement methodology was set January 1st, 2012 and is the same for both governmental and private individual practitioners. A unit of service is a visit or procedure as defined in the American Medical Association Current Procedural Terminology (AMA CPT). For dates of service between January 1, 2013 and December 30, 2014, provider rates for Evaluation and Management (E&M) procedure codes were set at 100 percent of Medicare mean. In addition the State will pay the federally calculated VFC vaccine administration charge. Physicians are reimbursed based on the current fee schedule available on the Department's website at:

health.maryland.gov/providerinfo

The Department does not pay for:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Outpatient Mental Health Clinics

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

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

- Both government and non-government practitioners are reimbursed pursuant to the same fee schedule. OMHCs are paid by CPT code or HCPCS codes which are based on Medicare reimbursement. The Department's methodology rates for OMHC providers are in effect as of January 1, 2012.

- State-developed fee schedule rates are the same for both governmental and private Updated rates are included on the current fee schedule which is published on the Department's website at:

health.maryland.gov/providerinfo

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Prosthetic Devices

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

The Department does not pay for:

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

The state-developed reimbursement methodology is effective July 1st, 2012 and is the same for both governmental and private practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

Reimbursement Methodology: Hospice Care

1. The Program will pay a hospice care provider at one of six rates for each day that a participant is under the provider's care. The daily payment rates for a provider for routine home care- first 60 days, routine home care-day 61 forward, service intensity add-on-last seven days of life, continuous home care, general inpatient care, and inpatient respite care will be in accordance with the Medicaid payment rates and the Medicare Wage Index established by the Centers Medicare and Medicaid Services (CMS) of the U.S Department of Health and Human Services for hospice care under a Medical Assistance Program. The rates and wage index are effective for services provided on or after the CMS publication date. Except as otherwise noted in the plan, state developed fee schedules and rates are the same for both governmental and private providers. The current fee schedule is published on the Department's website at:

   health.maryland.gov/providerinfo

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

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

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

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers of services provided under the Community First Choice Option. The Department's methodology was set on April 1st, 2017. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

I. State Plan Services

A. Personal Assistance Services: Rates are established using several factors. Preexisting rates across programs, collective bargaining with the Union, and the State's budget are all considered. Payment is based upon the total yearly budget established for personal assistance services for each participant as outlined per attachment 3.1 - K, page 3. Participants choosing to self direct will be able to set their rate, for independent providers, within a prescribed range. Providers of this service use a call-in system to clock in and out. Billing occurs based on an electronic claim generated by the call-in system in 15 minute increments. For individuals approved for up to 12 hours of personal assistance per day, payment will be made in 15-minute units of service. For individuals who are determined to need more than 12 hours of personal assistance per day, a daily rate for the service will be paid. All rates and rate ranges are defined in the above fee schedule.

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

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

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

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

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

The Department's fee schedule was set on October 1st, 2014 and is effective for services provided on or after that date. State developed fee schedule rates are the same for both governmental and private individual practitioners. Updated rates are included on the current fee schedule which is published on the Department's website at:

health.maryland.gov/providerinfo

For Individuals with Chronic Mental Illness, the following services:

☐ HCBS Day Treatment or Other Partial Hospitalization Services

☑ HCBS Psychosocial Rehabilitation

Intensive In-Home Services (IIHS) - EBP

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

a. are derived from rigorous, scientifically controlled research; and
b. can be applied in community settings with a defined clinical population;

2. has a consistent training and service delivery model;
3. utilizes a treatment manual; and
4. has demonstrated evidence that successful program implementation results in improved, measureable outcomes for recipients of the service intervention.

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

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

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

The Department's reimbursement methodology was set as of October 1st, 2014 and is effective for services provided on or after that date. The rates are the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

Personnel	Annual Amount or Rate	% FTE	Salary Cost	Fringe Benefits (25%)	Salary + Fringe Cost
Therapist	$ 50,000	0.50	$ 25,000	$ 6,250	$ 31,250.00
Supervisor/Clinical Lead	$ 75,000	0.20	$ 15,000	$ 3,750	$ 18,750.00
In-Home Stabilizer	$ 40,000	0.50	$ 20,000	$ 5,000	$ 25,000.00
Clinical Director	$ 100,000	0.08	$ 8,000	$ 2,000	$ 10,000.00

in the youth's home or community, as documented in the case notes. An individual can only receive IIHS services from one provider at a time. Partial hospitalization/day treatment, mobile crisis response services (MCRS), and other family therapies cannot be charged at the same time. IIHS providers are expected to provide crisis response services for the youth on their caseload.

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

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

The Department's reimbursement methodology was set on October 1st , 2014 and is effective for services provided on or after that date. State developed fee schedule rates are the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

MOBILE CRISIS RESPONSE SERVICES

MOBILE CRISIS & STABILIZATION SERVICES (MCRS)	Annual Amount or Rate	%FTE	Salary Cost	Fringe Benefits (30%)	Salary + Fringe Cost
Crisis Responder	$ 50,000.00	0.75	$ 37,500.00	$ 11,250.00	$ 48,750.00
Clinical Supervisor	$ 65,000.00	0.17	$ 10,833.33	$ 3,250.00	$ 14,083.33
Crisis Stabilizer	$ 35,000.00	0.25	$ 8,750.00	$ 2,625.00	$ 11,375.00
Administrative Support	$ 35,000.00	0.17	$ 5,833.33	$ 1,750.00	$ 7,583.33
Clinical Director	$100,000.00	0.06	$ 6,250.00	$ 1,875.00	$ 8,125.00
Total		1.40	$ 69,166.67	$ 20,750.00	$ 89,916.67
Other Costs (based on FTE)					
Rent (144 Square Feet @ $15 per square foot per FTE)					$ 3,015.00
Cellular Phone, Internet & Communications (@$110/month per FTE)					$ 1,842.50
Mileage (10,000 miles per year @ $0.555/mile)					$ 5,550.00
Insurance (general liability, professional liability) @$1,000 per FTE					$ 1,395.83
Indirect Cost (7% of salaries)					$ 4,841.67
		Total cost for 1 FTE crisis responder/stabilizer			$ 106,561.67
		Hourly rate			$ 102.46
		30 minute rate			$ 51.23
		15 minute rate			**$ 25.62**
		Assessment Rate: 3 hours			**$ 307.39**
Assumptions:					
50% time billable, assuming non-face to face crisis response and stabilization (e.g., crisis call, documentation, etc) is billable based on input from Milwaukee's Urgent Treatment Team experience					
Clinical supervisor oversees 6 crisis responders and 2 crisis stabilizers.					

Mobile Crisis Response and Stabilization (MCRS) providers may be reimbursed at a 15 minute service interval. There is also a single assessment rate for the

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

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

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

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

The Department's reimbursement methodology was set as of October 1st, 2014 and is effective for services provided on or after that date. State developed fee schedule rates are the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

Proposed Rates

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

LMHP=Licensed Mental Health Practitioner

ascertain how many of the expressive and experiential behavioral service providers were also licensed mental health clinicians and 2) encourage licensed mental health clinicians who were already Public Mental Health System providers to enroll to provide the additional service (a necessary step in helping families and youth to identify the most appropriate provider to address their needs). As a result, the higher rate was developed to address both of these issues through a mechanism to encourage provider enrollment and more accurately track provider utilization. The group rates were set based on the C&A Group Psychotherapy Rates.

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

The Department's methodology was set as of October 1st, 2014 and is effective for services provided on or after that date. State developed fee schedule rates are the same for both governmental and private individual practitioners. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerhealth

FAMILY PEER SUPPORT

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

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

provided on or after that date. State developed fee schedule rates are the same for both governmental and private individuals. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

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

☐ Other Services (specify below)

CUSTOMIZED GOODS AND SERVICES

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

Reimbursement for purchases under the Goods and Services benefit will require prior approval and be reviewed on a per request basis. Prior to reimbursement, it must be demonstrated that the purchaser received multiple quotes and paid a price that a prudent buyer would have paid. Claims under this benefit will be capped at $2,000 per year per beneficiary. The state must adhere to CMS record keeping requirements (42 CFR §431.107) and providers must keep records of documented medical necessity for CGS

Unallowable costs include, but are not limited to the following: Unallowable costs for customized goods and services include, but are not limited to the following:

(1) Alcoholic beverages;

(2) Bad debts;

(3) Contributions and donations;

(4) Defense and prosecution of criminal and civil proceedings, claims, appeals, and patent infringement;

(5) Entertainment costs

(6) Incentive compensation to employees;

(7) Personal use by employees of organization-furnished automobiles, including transportation to and from work;

(8) Fines and penalties;

(9) Goods or services for personal use;

(10) Interest on borrowed capital/lines of credit;

(11) Costs of organized fundraising;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community Personal Assistance Services 4.19B
State Plan Option Reimbursement

1) Effective October 1st, 2015, payments for community personal assistance services as defined per Attachment 3.1A page 31B shall be reimbursed in 15-minute units. Both government and non-government providers of community personal assistance services are reimbursed pursuant to the same fee schedule. The Department's reimbursement methodology was set on October 1st, 2015. The current fee schedule is published on the Department's website at:

   health.maryland.gov/providerinfo

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