# Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## Subtitle 09 MEDICAL CARE PROGRAMS

### Chapter 89 1915(i) Intensive Behavioral Health Services for Children, Youth, and Families

**Authority: Health-General Article, §§2-104(b), Annotated Code of Maryland**

10.09.89.01

### .01 Scope.

The purpose of this chapter is to implement a home and community-based services benefit for children and youth with serious emotional disturbances (SED) and their families, authorized under a 1915(i) Medicaid State Plan Amendment. Eligible participants are served by care coordination organizations through a wraparound service delivery model that utilizes child and family teams to create and implement individualized plans of care that are driven by the strengths and needs of the participants and their families.

10.09.89.02

### .02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) “1915(c)” means a federal waiver that allows states to provide home- and community-based care to individuals who would otherwise be institutionalized.

(2) “1915(i)” means the 1915(i) Intensive Behavioral Health Services for Children, Youth, and Families program described in this chapter.

(3) “Administrative services organization (ASO)” has the meaning stated in COMAR 10.09.62.01.

(4) “Behavioral Health Administration (BHA)” means the Department’s administration, as defined by Health General Article Title XX, Annotated Code of Maryland, or its designee.

(5) “Care coordinator” means an individual employed through the care coordination organization that is responsible for providing case management services to 1915(i) participants and families as described in COMAR 10.09.90.

(6) “Caregiver” means an individual with responsibility for 24-hour care and supervision of a minor.

(7) “Care coordination organization (CCO)” means an entity with a minimum of 3 years of experience providing care coordination services that is approved by the Department to provide case management services to 1915(i) participants and their families, pursuant to COMAR 10.09.90.

(8) “Child and family team (CFT)” means a team of individuals selected by the participant and family to work with them to design and implement the plan of care.

(9) “Core service agency (CSA)” has the meaning stated in COMAR 10.21.17.

(10) “Crisis plan” means a document that is developed by a CFT to address actions that need to be taken in the event that an individual is experiencing a behavioral health crisis, which is included as part of the plan of care.

(11) “Department” means the Maryland Department of Health and Mental Hygiene (DHMH) or its designee.

(12) “Department of Human Resources (DHR)” has the meaning stated in Human Services Article, Title 2, Annotated Code of Maryland.

(13) “Department of Public Safety and Correctional Services (DPSCS)” has the meaning stated in Correctional Services Article, Title 2, Annotated Code of Maryland.

(14) “Expressive and experiential behavioral services” means the use of art, dance, music, equine, horticulture, or drama to accomplish individualized goals as part of the plan of care.

(15) “Family” means:

(a) One or more parents and children related by blood, marriage, or adoption, and residing in the same household; or

(b) A parent substitute or substitutes, including informal and formal kinship caregivers as set forth in Health-General Article, §20-105, Annotated Code of Maryland, and Education Article, §7-101, Annotated Code of Maryland, or legal guardians, who have responsibility for the 24 hour care and supervision of a child.

(16) “Family peer support” means a service as described in Regulation .10 of this chapter.

(17) “Family peer support partner” means an individual providing family peer-to-peer support services.

(18) “Family support organization (FSO)”means an approved entity under Regulation .10D of this chapter.

(19) “Institution for mental disease (IMD)” has the meaning stated in COMAR 10.09.62.01B.

(20) “Local departments of social services (DSS)” has the meaning stated in Human Services Article, Title 3, Annotated Code of Maryland.

(21) “Maryland Children’s Health Program (MCHP)” has the meaning stated in COMAR 10.09.43.

(22) “Medical Assistance Program” has the meaning stated in COMAR 10.09.36

(23) “Mental health professional” has the meaning stated in COMAR 10.21.17.02.

(24) “Mobile crisis response and stabilization services (MCRS)” has the meaning stated in Regulation .13 of this chapter.

(25) “Natural support” means a family member, friend, or community member, or organization selected by the participant or family, or both, to participate on the CFT.

(26) “Participant” means an individual who meets the qualifications, as specified in Regulation .03 of this chapter, for benefit eligibility.

(27) “Plan of care (POC)” means a written document that is:

(a) Developed by the CFT that describes the services to be provided to the participant; and

(b) Approved by the Department in accordance with 42 CFR §441.301.

(28) “Office of Health Care Quality (OHCQ)” means the Office of Health Care Quality of the Department of Health and Mental Hygiene.

(29) “Program” means the Maryland Medical Assistance Program.

(30) “Provider” means an individual or entity that has enrolled with the Program to provide one or more benefit services covered under this chapter.

(31) “Public mental health system” means the system for the delivery of mental health treatment and supports to eligible individuals as described in COMAR 10.09.70.

(32) “Residential treatment center” has the meaning stated in Health-General Article, §19-301, Annotated Code of Maryland.

(33) “Room and board” means rent or mortgage, utilities, maintenance, furnishings, and food provided in or associated with an individual’s place of residence.

(34) “Respite care” has the meaning stated in COMAR 10.21.27.

(35) “Serious emotional disturbance (SED)” has the meaning stated in COMAR 10.21.17.

(36) “Service area” means, during the phase-in of the 1915(i), the geographic area in Maryland where the 1915(i) is available.

(37) “State Plan” means the Plan described in §1902(a) of Title XIX of the Social Security Act.

(38) “Supplemental Security Income (SSI)” means a federally administered program providing benefits to needy aged, blind, and disabled individuals under Title XVI of the Social Security Act, 42 U.S.C. §1381 et seq.

(39) “Wraparound” means a service delivery model that uses a collaborative process in which the CFT assists in the development and implementation of an individualized plan of care with specified outcomes.

10.09.89.03

## .03 Participant Eligibility.

A. For an applicant to be eligible for 1915(i) services, the applicant shall meet all of the criteria in §§B—H of this regulation.

B. The applicant shall be younger than 18 years old at the time of enrollment.

C. The applicant shall reside in a home-and community-based setting that is:

(1) Located in the 1915(i) service area; and

(2) Not any of the following excluded settings:

(a) Therapeutic Group Home (TGH) licensed by the Office of Health Care Quality (OHCQ) under COMAR 10.21.07;

(b) Psychiatric Respite Care facility located on the grounds of an institution for mental disease (IMD) for the purpose of placement;

(c) Residential program for adults with serious mental illness licensed under COMAR 10.21.22; or

(d) Group residential facility licensed under COMAR 14.31.05.07.

D. The family or medical guardian of the participant shall give consent to participate in the 1915(i), with consent given by the participant upon reaching age 18.

E. The applicant shall:

(1) Have a face-to-face psychiatric evaluation completed or updated within 30 days of submission of the enrollment application to the ASO that:

(a) Assigns a Diagnostic and Statistical Manual (DSM) behavioral health diagnosis;

(b) Determines the applicant to be amenable to active clinical treatment; and

(c) Is conducted by a provider not associated with the CCO by which the participant may eventually be served; and

(2) Meet the Department's written medical necessity criteria.

F. The accessibility or intensity of currently available community supports and services are inadequate to meet the applicant's needs due to the severity of the impairment without the provision of one or more of the services contained in the 1915(i) benefit.

G. The applicant may not be served in a Health Home as defined in COMAR 10.09.33 while enrolled in the 1915(i).

H. Medical Assistance Eligibility.

(1) Categorically Needy. An applicant is eligible for 1915(i) services if the applicant is eligible for Medicaid or Maryland Children's Health Program (MCHP) in accordance with COMAR 10.09.11 or 10.09.24 and has a family income that does not exceed 150 percent of the Federal Poverty Line (FPL).

(2) Optional Categorically Needy. An applicant is eligible for the 1915(i) benefit as optionally categorically needy in accordance with 1902(a)(10)(A)(ii)(XXII) if the individual is receiving services through an existing 1915(c) HCBS waiver program.

I. The Department may assist applicants in the benefit application process by:

(1) Informing the applicant and family verbally and in writing about services available in the 1915(i);

(2) Assisting the applicant and family to complete the eligibility determination for Medical Assistance for the 1915(i), if necessary; and

(3) Once Medical Assistance eligibility is determined, ensuring that the assessments and documentation required for a medical necessity determination are obtained and provided to the Department.

J. Based on the criteria established in §§A—H of this regulation:

(1) An applicant's eligibility for services under this regulation shall be established by the Department;

(2) There is no retroactive eligibility; and

(3) Benefit eligibility may not begin before:

(a) Verification of the applicant's Medical Assistance eligibility for the 1915(i); and

(b) Completion of the independent evaluation by the Department that the applicant meets all criteria established in §§A—H of this regulation.

K. If the applicant is determined to meet the needs-based eligibility criteria as established in §§A—H of this regulation, the Department shall:

(1) Obtain written consent from the family or medical guardian to participate in the 1915(i); and

(2) Ensure that the participant is referred immediately upon enrollment determination to a CCO.

L. The Department shall re-evaluate a participant's:

(1) Needs-based eligibility for 1915(i) services as specified in §§A—G of this regulation every 12 months, or more frequently due to a significant change in the participant's condition or needs, in accordance with the Department's medical necessity criteria; and

(2) Medical Assistance eligibility for 1915(i) services in accordance with the Department's redetermination policy for all Medical Assistance enrollees.

10.09.89.04

## .04 Termination of Participant Enrollment.

A. A participant shall be disenrolled from the 1915(i), as of the date established by the Department, if the participant:

(1) No longer meets all of the criteria for 1915(i) eligibility specified in §§A—H of Regulation .03 of this chapter;

(2) Voluntarily chooses to disenroll from the benefit, if the participant is 18 years old, or the participant's family or medical guardian chooses to do so on behalf of a participant who is younger than 18 years old or in the custody of the State, or both;

(3) Is hospitalized for longer than 30 days;

(4) Moves out of the service area and cannot reasonably access services and supports;

(5) Is admitted to and placed in an RTC for longer than 60 days;

(6) Is admitted to and placed in a Therapeutic Group Home (TGH) licensed by OHCQ under COMAR 10.21.07 or an adult residential program approved under COMAR 10.21.22;

(7) Is placed in a Psychiatric Respite Care program, a non-medical group residential facility located on the grounds of an IMD primarily for the purpose of placement;

(8) Loses eligibility for Maryland Medical Assistance;

(9) Turns 22 years old;

(10) Is detained, committed to a juvenile justice or correctional facility, or incarcerated for longer than 60 days;

(11) Does not meet medical re-certification criteria;

(12) Does not participate in a Child and Family Team (CFT) meeting within 90 days;

(13) Is no longer actively engaged in ongoing behavioral health treatment with a licensed mental health professional; or

(14) Is placed in a group residential facility licensed under COMAR 14.31.05—.07.

B. A participant who is not receiving 1915(i) services continuously after reaching age 18 is ineligible to enroll in the program at a later date.

10.09.89.05

## .05 1915(i) Model.

A. The 1915(i) shall provide community-based treatment to children with SED through a wraparound service delivery process.

B. Enrollment in 1915(i) services qualifies and requires the participant to receive case management services through a CCO, pursuant to COMAR 10.09.90.

C. Each participant shall have an individualized POC that is managed by the CCO, pursuant to COMAR 10.09.90:

D. In partnership with the CFT, the CCO shall:

(1) Reevaluate the POC at least every 45 days with re-administration of BHA-approved assessments as appropriate, and more frequently in response to a crisis;

(2) Determine the family vision, which will guide the planning process;

(3) Identify strengths of the entire team;

(4) Determine the needs that the team will work on;

(5) Determine outcome statements for meeting identified needs;

(6) Determine the specific services and supports required in order to achieve the goals identified in the POC;

(7) Create a mission statement that the team generates and commits to following;

(8) Identify the individuals responsible for each of the strategies in the POC;

(9) Review and update the crisis plan; and

(10) Meet at least every 45 days or more frequently as clinically indicated to:

(a) Coordinate the implementation of the POC; and

(b) Re-evaluate and update the POC as necessary.

E. Benefit participants shall have access to specialty behavioral health services through the Department's public behavioral health system. Participants shall also be enrolled in the Medical Assistance Program's managed care program, known as HealthChoice, in accordance with eligibility requirements set forth in COMAR 10.09.63.

10.09.89.06

## .06 Conditions for Provider Participation.

A. The Department shall grant approval to providers to be eligible to receive Medicaid funds for 1915(i) services if the provider meets the requirements set forth in this chapter.

B. Application. To provide 1915(i) services, a provider applicant shall:

(1) Submit an application to the Department on the form approved by the Department, with all questions answered and all required documents attached; and

(2) Attest that the provider applicant is in compliance with the general provider requirements and specific 1915(i) service requirements set forth in this chapter and in COMAR 10.09.36.

C. Application Modification.

(1) A provider that proposes to change its 1915(i) service sites by adding, closing, or moving locations shall submit an application modification, on the form required by the Department, to the Department.

(2) If the Department approves the application modification, the existing provider approval shall extend to the additional site, as applicable.

D. Approval.

(1) The Department may grant approval to an applicant provider if the Department determines that the provider:

(a) Has no deficiencies that constitute a threat to the health, safety, or welfare of the individuals served; and

(b) Attests that it complies with the requirements set forth in this chapter.

(2) If the provider is granted approval under §D(1) of this regulation, to continue to be approved, the provider shall maintain documentation of compliance with the requirements set forth in this chapter.

E. Sale or Transfer of Approval.

(1) The Department's approval of a 1915(i) service provider is valid only for the provider to which the Department grants approval.

(2) A provider may not sell, assign, or transfer approval to another provider.

10.09.89.07

## .07 Denial, Emergency Suspension of Approval, and Disciplinary Action.

A. Denial of Approval.

(1) If the Department proposes to deny approval to an applicant under the provisions of this chapter, the Department shall give written notice of the proposed denial to the:

(a) Provider applicant;

(b) Care coordination organization (CCO); and

(c) Administrative service organization (ASO).

(2) In the notice under §A(1) of this regulation, the Department shall include:

(a) The date on which the Department proposes to deny approval;

(b) The facts that warrant the proposed denial of approval;

(c) Citation of the regulation or regulations upon which the proposed denial is based;

(d) Notification that before the denial of approval, the provider may request a hearing under the provisions of COMAR 10.21.16; and

(e) When feasible, notification of a case resolution conference.

B. Disciplinary Action.

(1) The Department may propose to take any of the following disciplinary actions against a provider:

(a) Revocation of approval;

(b) Suspension of approval;

(c) Probation with conditions; or

(d) Banning new admissions.

(2) The Department may propose to take one of the actions outlined in §B(1) of this regulation if the provider:

(a) Is out of compliance with the requirements of this chapter;

(b) Fails to maintain financial viability; or

(c) Obtains or attempts to obtain approval or payment by fraud, misrepresentation, or the submission of false information to the Department.

(3) Except under §C of this regulation, the Department shall send written notice of the proposed action not less than 45 calendar days in advance of the proposed action taken under this regulation to the:

(a) Provider;

(b) CCO;

(c) ASO; and

(d) Applicable CSA.

(4) In the notice under §B(3) of this regulation, the Department shall include:

(a) The date on which the Department proposes to take action and, when feasible, the date of a case resolution conference;

(b) The facts that warrant the proposed action;

(c) Citation of the regulation or regulations upon which the proposed action is based; and

(d) Notification that, before the action, the provider has the right to request a hearing under the provisions of COMAR 10.21.16.

(5) If, after notice and opportunity to be heard, the Department takes disciplinary action, the provider shall, within 10 working days:

(a) Notify individuals or the guardians of individuals receiving services of the action; and

(b) If the program ceases operations:

(i) Notify individuals or the guardians of individuals receiving services of the suspension; and

(ii) Cooperate with the CCO, child and family team, and the Department in accessing appropriate alternate services for individuals served by the provider.

C. Emergency Suspension of Approval.

(1) Under State Government Article, §10-226, Annotated Code of Maryland, upon findings of conditions that pose an imminent risk to the health, safety, or welfare of an individual served by a provider, the Department may order the immediate suspension of the approval of the provider and the cessation of operation.

(2) If the Department takes the action under §C(1) of this regulation, the Department shall promptly give written notice of the proposed emergency suspension to the:

(a) Provider;

(b) CCO;

(c) ASO; and,

(d) Applicable CSA.

(3) In the notice under §C(2) of this regulation, the Department shall include:

(a) The proposed effective date of the emergency suspension;

(b) When feasible, the date of a pre-deprivation hearing and a case resolution conference before the Department's final action;

(c) The findings under §C(1) of this regulation and the reasons that support the findings; and

(d) Notification that:

(i) Following the emergency suspension, the provider may request a hearing under the provisions of COMAR 10.21.16; and

(ii) The emergency suspension may lead to revocation of the approval if the violation or violations are not corrected within the time period specified by the Department.

(4) If the Department suspends approval, the provider shall immediately:

(a) Notify individuals or the guardians of individuals receiving services of the suspension;

(b) Cooperate with the CCO, child and family team, and the Department in accessing appropriate alternate services for individuals in the program; and

(c) Cease operations of the program.

10.09.89.08

## .08 General Conditions for 1915(i) Services Provider Participation.

A. A provider of 1915(i) services shall:

(1) Provide the documentation required by the Department for initial approval and provider recertification, or as requested by the Department;

(2) Be approved by the Department as meeting the requirements of being able to provide the services set forth in this chapter;

(3) Have a provider agreement in effect, to include adherence to quality assurance, auditing, and monitoring policies and procedures;

(4) Receive training and certification as required and approved by the Department and determined to be appropriate for the level and scope of services provided;

(5) Meet all the conditions for participation in COMAR 10.09.36 except as otherwise specified in this chapter;

(6) Maintain general liability insurance, and provide proof of this insurance:

(a) At the time of initial application to be a provider of 1915(i) services;

(b) At recertification; and

(c) Upon request by the Department;

(7) Make available to the Department and federal funding agents all records for inspection and copying, including but not limited to:

(a) Personnel files for each individual employed, regardless of method of compensation;

(b) Financial records;

(c) Treatment records; and

(d) Service records;

(8) Comply with the following prohibitions against utilization of staff:

(a) Unless waived by the Department in accordance with §D of this regulation, 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

(ii) Has an indicated finding of child abuse or neglect; and

(9) Maintain administrative and medical records documenting the date, time, duration, and substantive notes associated with the services delivered, which shall be signed by the provider and indicated by the participant's plan of care.

B. Required Criminal Background Checks. The provider shall, at the provider's own expense and for all staff, volunteers, students, and any individual providing services to participants and their families in the 1915(i):

(1) 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), in accordance with Family Law Article, §5-561, Annotated Code of Maryland;

(2) Request that DPSCS send the report to:

(a) 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

(b) To the Department's designee, if the provider is a self-employed, independent practitioner, or the director of the agency; and

(3) Review the results of the background checks;

(4) Store background checks in a secure manner consistent with State and federal law; and

(5) 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 the criteria set forth in this regulation.

C. Required Check for Abuse or Neglect. For each individual providing services to participants and the participant's families in the 1915(i), the provider shall:

(1) Before employing any individual, submit a notarized Consent for Release of Information/Background Clearance Request form to the Department of Human Resources (DHR) or a local department of social services (DSS) in the jurisdiction in which the individual lives, pursuant to COMAR 07.02.07.19; and

(2) Request that DHR or the local DSS send the report to:

(a) The director of the agency if the request is from a provider agency concerning staff, volunteers, or students who will work with the participant or family; or

(b) To the Department's designee, if the provider is a self-employed, independent practitioner, or the director of the agency.

D. To provide 1915(i) services, an individual may not:

(1) Be the participant's family member;

(2) Have been convicted of, received probation before judgment for, or entered a plea of nolo contendere to, a felony or any crime involving moral turpitude or theft, or have any other criminal history that indicates behavior which is potentially harmful to participants; or

(3) 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.

E. 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:

(1) For criminal background checks:

(a) The conviction, the probation before judgment, or plea of nolo contendere to the felony or the crime involving moral turpitude or theft was entered more than 10 years before the date of the employment application;

(b) The criminal history does not indicate behavior that is potentially harmful to participants; and

(c) Includes a statement from the individual as to the reasons the prohibition should be waived; and

(2) For abuse and neglect findings:

(a) The indicated finding occurred more than 7 years before the date of the clearance request;

(b) The summary of the indicated finding does not indicate behavior that is potentially harmful to the participant or the participant's family; and

(c) Includes a statement from the individual as to the reasons the prohibition should be waived.

F. The Program covers the services listed in this chapter when the services are:

(1) Determined by the Department to be medically necessary;

(2) Preauthorized by Department; and

(3) Delivered in accordance with the participant's POC.

10.09.89.09

## .09 Covered Services — Customized Goods and Services.

A. Customized goods and services are:

(1) Expenditures requested by the participant's CCO and made by the CSA to support the POC for the participant and family for costs that are:

(a) 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; and

(b) Necessary, defined as those that are likely to improve outcomes or remediate a particular and specified need identified in the POC, to include:

(i) Success in an educational or vocational setting;

(ii) Maintaining the youth in the home;

(iii) Development and maintenance of healthy relationships;

(iv) Prevention of or reduction in adverse outcomes (e.g., arrest, delinquency, victimization, and exploitations); or

(v) Becoming or maintaining a stable and productive member of the community; and

(2) Used as a funding source of last resort, only for those costs that cannot be covered by any other source and are vital to the implementation of the POC.

B. A CSA may provide customized goods and services if the CSA:

(1) Has a written customized goods and services policy and procedures that:

(a) Ensures accountability;

(b) Ensures that all customized goods and services expenditures are verifiable; and

(c) Is revised as needed;

(2) Communicates any changes made to their customized goods and services policy to all parties;

(3) Accounts for all funds used; and

(4) Complies with requirements established by the Department.

10.09.89.10

## .10 Covered Services — Family Peer Support Services.

Family peer support services:

A. May be provided without the presence of the participant;

B. Are delivered by a family peer support partner employed by a family support organization (FSO);

C. May include, but are not limited to:

(1) Explaining the role and function of the FSO to newly enrolled families and creating linkages to other peers and supports in the community;

(2) Working with the participant and family to identify and articulate concerns, needs, and vision for the future of the participant;

(3) Ensuring family and participant opinions and perspectives are incorporated into the CFT process and POC:

(a) Through communication with the care coordinator and team members; and

(b) By attending CFT meetings with the family to support family decision-making and choice of options;

(4) Listening to the family express needs and concerns and offering suggestions for engagement in the treatment process;

(5) Helping the family identify and engage its own natural support system and facilitating the family attending peer support groups and other FSO activities throughout the POC process;

(6) Working with the family:

(a) To organize and prepare for meetings in order to maximize participation in meetings;

(b) By informing the family about options and possible outcomes in selecting services and supports to assist with informed decision-making; and

(c) By supporting the family in meetings at school and other locations in the community and during court hearings;

(7) Empowering the family to make choices to achieve desired outcomes for the participant as well as the entire family; and

(8) Helping the family to acquire the skills and knowledge needed to attain greater self-sufficiency and maximum autonomy and assisting the family to develop the skills and confidence to independently identify, seek out and access resources that will assist in:

(a) Managing and mitigating the participant's behavioral health condition or conditions;

(b) Preventing the development of secondary or other chronic conditions;

(c) Promoting optimal physical and behavioral health; and

(d) Addressing and encouraging activities related to health and wellness.

D. Are provided by a family support organization (FSO) that:

(1) Is designated as a private, nonprofit entity designated under §501(c)(3) of the Internal Revenue Service Code, and submits copies of the certificate of incorporation and Internal Revenue Service designation;

(2) Has a board of directors comprised of more than 50 percent of individuals who are:

(a) Caregivers with a current or previous primary daily responsibility for raising a child or youth with behavioral health challenges,

(b) Individuals who have experience with State or local services and systems as a consumer who has or had behavioral health challenges; or

(c) Both §D(2)(a) and (b) of this regulation.

(3) Submits a list of board members with identification of those who are caregivers meeting the criteria in §D(2)(b) of this regulation;

(4) Establishes hiring practices that give preference to:

(a) Current or previous caregivers of a child or youth with behavioral health challenges;

(b) Individuals who have experience with State or local services and systems as a consumer who has or had behavioral health challenges; or

(c) Both §D(4)(a) and (b) of this regulation;

(5) Submits a copy of the organization's personnel policy that sets forth the preferred employment criteria stated in §D(4) of this regulation;

(6) Employs a staff that is comprised of at least 75 percent of individuals who are:

(a) Current or previous caregivers of a child or youth with behavioral health challenges; or

(b) Individuals who have experience with State or local services and systems as a consumer who has or had behavioral health challenges;

(7) Submits a list of staff and positions held with identification of those who fit the experienced caregiver and consumer criteria stated in §D(6) of this regulation; and

(8) Submits a certificate of eligibility that includes:

(a) Attestation of compliance with §D(1)—(6) of this regulation; and

(b) The organization's mission statement that establishes the purpose of the organization as providing support and education to youth with emotional, behavioral, or mental health challenges and their caregivers;

E. Shall be provided by family peer support partners who:

(1) Are employed by an FSO;

(2) Are 18 years old or older;

(3) Receive supervision from an individual who:

(a) Is 21 years old or older; and

(b) Has at least 3 years of experience providing family peer-to-peer support or working with children with serious behavioral health challenges and their families;

(4) Have current or prior experience as a caregiver of a child with behavioral health challenges or be an individual who has experience with State or local services and systems as a consumer who has or had behavioral health challenges; and

(5) Receive training and certification as approved by the Department; and

F. Are reimbursed at the following rates:

(1) $15.97 per 15 minute unit for face-to-face services; or

(2) $7.98 per 15 minute unit for telephonic or other non- face-to-face activities.

10.09.89.11

## .11 Covered Services — Respite Services.

Respite services:

A. Include a set of specific short-term services documented in the POC that include:

(1) A schedule of the participant's activities during respite;

(2) Medication monitoring, if needed;

(3) The frequency, duration, and intensity of staff support;

(4) Respite locations; and

(5) The aftercare plan or recommendations;

B. Include community-based respite services, which are provided in the participant's home or other community-based setting;

C. Include out-of-home respite services, which provide a temporary overnight living arrangement outside of the participant's home;

D. Are provided by organizations that shall:

(1) Meet the requirements of COMAR 10.21.27;

(2) Employ respite care specialists who are:

(a) 21 years old or older and have a high school diploma or high school equivalency; or

(b) At least 18 years old and enrolled in, or in possession of at least an associate degree from, an accredited college or university in a human services field, and are limited to providing services to participants under 13 years of age;

(3) Ensure that community-based respite services are provided in the participant's home or other community-based setting; and

(4) Ensure that out-of-home respite services are:

(a) Provided in a community-based temporary overnight living arrangement outside the participant's home; and

(b) Where applicable, delivered in accordance with COMAR 14.31.05—14.31.07; and

E. Are reimbursed at the following rates:

(1) $25.16 per one hour unit of service for community-based respite services; or

(2) $199.44 per unit of out-of-home respite care.

10.09.89.12

## .12 Covered Services — Expressive and Experiential Behavioral Services.

A. Expressive and experiential behavioral services:

(1) May be provided to an individual or group;

(2) Provide sensory modalities to participants to assist in achieving POC objectives; and

(3) Include:

(a) Art behavioral services;

(b) Dance behavioral services;

(c) Equine-assisted behavioral services;

(d) Horticultural behavioral services;

(e) Music behavioral services; or

(f) Drama behavioral services.

B. Qualification to Provide Expressive and Experiential Behavioral Services.

(1) To provide expressive and experiential behavioral services, an individual shall have:

(a) A bachelor's or master's degree from an accredited college or university; and

(b) Current registration in the applicable association as outlined in §E(5) of this regulation;

(2) Association Registration.

(a) Art Behavioral Services. To provide art behavioral services, an individual shall be currently registered as a registered art therapist by:

(i) The Art Therapy Credentials Board in the American Art Therapy Association; or

(ii) A comparable association with equivalent requirements.

(b) For Dance Behavioral Services. To provide dance behavioral services, an individual shall be currently registered as a dance therapist registered, or an academy of dance therapists registered in:

(i) The American Dance Therapy Association; or

(ii) A comparable association with equivalent requirements.

(c) For Equine-Assisted Behavioral Services. To provide equine-assisted behavioral services, an individual shall be currently certified by:

(i) The Equine Assisted Growth and Learning Association (EAGALA) to provide services under the EAGALA model;

(ii) Professional Association of Therapeutic Horsemanship International (PATHI); or

(iii) A comparable association with certification requirements at least equivalent to EAGALA or PATHI.

(d) For Horticultural Behavioral Services. To provide horticultural behavioral services, an individual shall be currently registered as a horticultural therapist registered in:

(i) The American Horticultural Therapy Association; or

(ii) A comparable association with equivalent requirements.

(e) For Music Behavioral Services. To provide music behavioral services, an individual shall be currently registered as a music therapist-board certified by:

(i) The Certification Board for Music Therapists, Inc; or

(ii) A comparable association with equivalent requirements.

(f) For Drama Behavioral Services. To provide psychodrama/drama behavioral services, an individual shall be currently registered as a registered drama therapist or a board certified trainer in:

(i) The National Association for Drama Therapy; or

(ii) A comparable association with equivalent requirements.

C. Reimbursement. Reimbursement for services described in this regulation shall be as follows:

(1) For individual therapy provided by a:

(a) Licensed mental health professional at a rate of:

(i) $68.41 per 45—50 minute session; or

(ii) $89.62 per 75—80 minute session;

(b) Non-licensed mental health professional at a rate of:

(i) $62.19 per 45-minute session; or

(ii) $80.85 per 75—80 minute session; and

(2) For group therapy provided by a:

(a) Licensed mental health professional at a rate of:

(i) $27.20 per 45—60 minute session; or

(ii) $35.36 per prolonged (75—90 minute) session;

(b) Non-licensed mental health professional at a rate of:

(i) $24.16 per 45—60 minute session; or

(ii) $31.41 per prolonged (75—90 minute) session.

10.09.89.13

## .13 Covered Services — Mobile Crisis Response Services.

A. Mobile crisis response services (MCRS):

(1) Are offered in response to urgent mental health needs;

(2) Are available on a short-term on-call basis 24 hours per day, 7 days per week;

(3) Are coordinated with the care coordinator and CFT, and are incorporated into the participant's POC;

(4) Are short-term, individualized services that assist in de-escalating crises and stabilizing children and youth in their home and community setting;

(5) Are designed to:

(a) Maintain the participant in the participant's current living arrangement;

(b) Prevent movement from one living arrangement to another; and

(c) Prevent repeated hospitalizations;

(6) Include the delivery of a variety of flexible services detailed in a comprehensive, individualized plan for stabilization that:

(a) Addresses safety concerns and risk factors, including the family's definition of the crisis;

(b) Includes family triggers, strengths, and supports; and

(c) Identifies both immediate and continued interventions to ensure stabilization in the home and community setting, which may include:

(i) Strategies to de-escalate and prevent a crisis situation;

(ii) Short-term in-home therapy;

(iii) Behavioral management and support;

(iv) Coordination and development of natural supports; and

(v) Skills training on coping and activities of daily living; and

(7) May be provided in any community location to prevent emergency room visit, hospitalization, or movement from one living arrangement to another, including but not limited to the:

(a) Family home;

(b) Foster home;

(c) School; and

(d) Emergency room.

B. MCRS are provided by organizations that:

(1) Are approved by the Department as:

(a) A provider of Mobile Treatment Services, as outlined in COMAR 10.21.19;

(b) A provider of Psychiatric Rehabilitation Services for Minors, as outlined in COMAR 10.21.29; or

(c) An Outpatient Mental Health Clinic (OMHC), as outlined in COMAR 10.21.20;

(2) Have capacity to provide or arrange for immediate crisis services 24 hours a day, 7 days per week, including:

(a) Face-to-face clinical care;

(b) Psychiatric consultation; and

(c) Person-to-person phone coverage;

(3) Employ clinical supervisors who:

(a) Are licensed and in good standing under Health Occupations Article, Annotated Code of Maryland, as a:

(i) Psychiatrist;

(ii) Psychologist;

(iii) Licensed certified social worker-clinical (LCSW-C);

(iv) Licensed clinical professional counselor (LCPC);

(v) Nurse psychotherapists; or

(vi) Advanced practice registered nurse—psychiatric mental health (APRN-PMH);

(b) Are permitted to provide supervision under their respective practice act; and

(c) Have experience providing crisis response services;

(4) Employ crisis responders who are psychiatrists, psychologists, LCSW-C, LCSW, LCPC, nurse psychotherapists, or APRN-PMH, as outlined in the Health Occupations Article, Annotated Code of Maryland; and

(5) Employ crisis stabilizers who:

(a) Are 21 years old or older;

(b) Have a bachelor's degree in a human services field; and

(c) Receive initial and ongoing training in crisis response and stabilization.

C. The MCRS provider may be reimbursed for:

(1) An assessment, which is pre-authorized for all participants and conducted prior to a crisis, in coordination and, together, where possible, with the care coordinator to develop an initial crisis plan within the first week of enrollment in the 1915(i);

(2) Crisis response, which is an in-person response to the location where a crisis is occurring to assess, de-escalate, and provide initial stabilization pre-authorized for all participants up to 3 days; and

(3) Stabilization, which is in-person support:

(a) Following a crisis response and dependent upon obtaining prior-authorization, to support revisions to the crisis plan and provide education and training on preventing and responding to crises; or

(b) Provided at the recommendation of the CFT to prevent a crisis.

D. MCRS are reimbursed at the following rates:

(1) $25.62 per 15 minute unit of service for crisis response or stabilization; and,

(2) $307.39 per assessment.

10.09.89.14

## .14 Covered Services — Intensive In-Home Services.

A. Intensive In-Home Services (IIHS):

(1) Are strengths-based interventions with the child and his or her identified family that includes a series of components, such as:

(a) Functional assessments and treatment planning;

(b) Individualized interventions;

(c) Crisis response and intervention; or

(d) Transition support;

(2) May be provided to the child alone, to other family members, or to the child and family members together;

(3) Are intended to support a child to remain in his or her home and reduce hospitalizations and out-of-home placements or changes of living arrangements through focused intervention in the home and community; and

(4) May be used in situations such as the start of a child's enrollment in the 1915(i), upon discharge from a hospital or residential treatment center, or to prevent or stabilize after a crisis situation.

B. Types of IIHS Providers. The Department may approve two types of IIHS providers:

(1) Evidence-Based Practice (EBP)-IIHS providers, to include providers of Functional Family Therapy (FFT) and other EBPs, as determined by the Department; and

(2) Promising Practice IIHS providers (non-EBP), to include providers of the In-Home Intervention Program for Children (IHIP-C) and other promising practices, as determined by the Department.

C. A EBP-IIHS provider shall have a certificate or letter from the national or intermediate surveyor or developer of the particular evidence-based practice to demonstrate that the EBP-IIHS provider meets all requirements for FFT or other Department-approved EBP-IIHS, to include participating in all fidelity monitoring activities.

D. A Non-EBP IIHS provider shall:

(1) Be a Department-approved IHIP-C provider or have a certificate or letter from a national or intermediate purveyor or developer of another promising practice; and

(2) Meet the requirements of §E of this regulation.

E. All non-EBP IIHS providers not approved by the Department as IHIP-C providers shall:

(1) Ensure that there are Clinical Supervisors and staff who are responsible for creating, implementing, and managing the treatment plan with the child and family and the CFT;

(2) Provide crisis response services for the participants on the IIHS provider's caseload and ensure that on-call and crisis intervention services are:

(a) Provided by a licensed mental health professional trained in the intervention;

(b) Available 24-hours per day, 7 days per week, during the hours the provider is not open to the individual enrolled in the treatment; and

(c) In compliance with staffing, supervision, training, data collection, and fidelity monitoring requirements set forth by the purveyor, developer, or DHMH and approved by the Department;

(3) Employ Clinical Supervisors who:

(a) Have a current license under the Health Occupations Article, Annotated Code of Maryland, as a:

(i) Licensed certified social worker-clinical (LCSW-C);

(ii) Licensed clinical professional counselor (LCPC);

(iii) Psychologist;

(iv) Psychiatrist;

(v) Nurse psychotherapist; or

(vi) Advanced practice registered nurse/psychiatric mental health (APRN-PMH); and

(b) Have at least 3 years of experience in providing mental health treatment to children and families;

(4) Employ mental health professionals who:

(a) Have a current license under the Health Occupations Article, Annotated Code of Maryland, as a:

(i) Licensed certified social worker (LCSW);

(ii) LCSW-C;

(iii) LCPC;

(iv) Psychologist;

(v) Psychiatrist;

(vi) Nurse psychotherapist; or

(vii) APRN-PMH.

(b) Are supervised by a clinical lead supervisor;

(c) See the child in-person at least once per 7 days while receiving IIHS services;

(5) Employ in-home stabilizers who:

(a) Support the implementation of the treatment plan, but are not responsible for creating it or modifying it;

(b) Are at least 21 years old;

(c) Have at least a high school diploma or equivalency; and

(d) Have completed relevant, comprehensive, appropriate training before providing services, as outlined by the purveyor, developer, or the Department and approved by the Department;

(6) Provide a minimum of one face-to-face contact with the participant per week of service;

(7) Ensure a minimum of 50 percent of the mental health professionals' contacts with the participant or family, or both, is face-to-face; and

(8) Ensure that a minimum of 50 percent of the mental health professionals' time is spent working outside the agency's office and in the participant's home or community, as documented in case notes.

F. Reimbursement for IIHS services shall be provided at the rate of:

(1) $248.90 per week of service for EBP-IIHS providers; or

(2) $197.47 per week of service for non-EBP IIHS providers.

10.09.89.15

## .15 Limitations.

A. Reimbursement shall be made by the Program only when all of the requirements of this chapter are met.

B. The Program may not reimburse for:

(1) Services that are:

(a) Provided by a member of the recipient's immediate family or an individual who resides in the recipient's home;

(b) Not preauthorized by the Department;

(c) Not medically necessary;

(d) Beyond the provider's scope of practice;

(e) Provided at no charge to the general public;

(f) Not appropriately documented;

(g) Part of another service paid for by the State; or

(h) Provided without a valid required license or appropriate credentials as specified in this chapter;

(2) Completion of forms or reports;

(3) Broken or missed appointments;

(4) Time spent in travel by the provider to and from site of service, except when with the participant or the participant's family; or

(5) Costs of travel by the provider to and from the site of service.

C. The Program may not reimburse more than the following:

(1) 1 session per day for out-of-home respite;

(2) 6 hours per day of community-based respite;

(3) 24 overnight units of respite annually;

(4) 2 types per day of expressive and experiential behavioral services;

(5) $2,000 per participant per State Fiscal Year for customized goods and services;

(6) 1 MCRS assessment for the development of the initial crisis plan.

D. Intensive in-home services may not be reimbursed for the same day of service or on the same day of service as:

(1) Partial hospitalization/day treatment;

(2) Mobile crisis response services; or

(3) Other family therapies.

E. Out-of-home respite and community-based respite services may not be reimbursed for the same day of service or on the same day of service as:

(1) Residential rehabilitation;

(2) Therapeutic behavioral services; or

(3) Any other public mental health system respite services.

F. Out-of-home respite and community-based respite services do not include on-going day care or before or after school programs.

G. Out-of-home respite and community based respite services may not be delivered to youth residing in Treatment Foster Care.

H. 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;

(12) Costs of investment counsel/management;

(13) Lobbying; or

(14) Renovation/remodeling and capital projects.

I. No more than 25 percent of the family support organization's claims in a 30-day period for family peer support may be telephonic for a participant or the participant's family.

10.09.89.16

## .16 Payment Procedures.

A. Request for Payment.

(1) An approved provider shall submit requests for payment for the services covered under this chapter according to the procedures set forth in COMAR 10.09.36.04.

(2) The provider shall:

(a) Bill the ASO in accordance with the payment methodology specified in this chapter;

(b) Accept payment from the ASO as payment in full for the covered services rendered, and make no additional charge to the participant or any other party for these services; and

(c) Submit a request for payment in a manner approved by the Program, which includes a certification of the:

(i) Date or dates of service;

(ii) Participant's name and Medicaid number;

(iii) Provider's name, location, and provider identification number;

(iv) Type, procedure code or codes, and unit or units of covered services provided; and

(v) Amount of reimbursement requested.

B. Documentation Required.

(1) Payments by the Program or its designee may be withheld or recovered if the provider fails to submit:

(a) Requested evidence of services provided;

(b) Staff qualifications;

(c) Corrective action plans; or

(d) Any other types of documentation related to ensuring the health and safety of a participant.

(2) Payments shall be released upon receipt and approval by the Program or its designee of the requested documentation.

(3) An appeal by the provider under COMAR 10.01.03 does not stay the withholding of payments.

C. Billing time limitations for the services covered under this chapter are the same as those set forth in COMAR 10.09.36.06.

D. Payments.

(1) Payments shall be made only for services rendered by a 1915(i) provider approved by the Department and enrolled as a Medicaid provider.

(2) Services will only be paid when delivered in accordance with the POC that has been authorized by the Department.

(3) The Program shall pay according to the fee-for-service schedule for each of the covered services, as set forth in this regulation.

10.09.89.17

## .17 Recovery and Reimbursements.

Recovery and reimbursement are set forth in COMAR 10.09.36.07.

10.09.89.18

## .18 Cause for Suspension or Removal and Imposition of Sanctions.

Cause for suspension or removal and imposition of sanctions is as set forth in COMAR 10.09.36.08 and 10.21.10.

10.09.89.19

## .19 Appeal Procedures for Providers.

Appeal procedures for providers are those set forth in COMAR 10.09.36.09.

10.09.89.20

## .20 Appeal Procedures for Applicants and Participants.

Appeal procedures for applicants and participants are those set forth in COMAR 10.01.04, 10.09.24.13, and 10.09.70.

**Administrative History**

**Effective date: October 1, 2014 (41:19 Md. R. 1077)**