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

State/Territory: Maryland

CASE MANAGEMENT SERVICES
FOR HIV-Infected Individuals

A. Target Group:

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

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

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

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

D. Definition of Services:

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

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

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

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

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

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

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

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

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

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

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

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

E. Qualifications of Providers:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e) Provide ongoing case management services to participants.

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

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

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

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

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

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

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

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

   d) The completed bio-psychosocial assessment.

   e) The completed plan of care signed by all members of the multidisciplinary team.

   f) Documentation for each contact made by the case manager including:
      i) Date and subject of contact;
      ii) Person contacted;
      iii) Person making the contact;
      iv) Nature, extent, and unit or units of service provided; and
      v) Place of service.

   g) A signed case closure form when ongoing case management services are ended.

F. Freedom of Choice:

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

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Access to Services:

The state assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.

2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

4. The State assures that the amount, duration, and scope of the case management activities would be documented in a participant's plan of care.

H. Payment

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

I. Case Records:

Providers maintain medical records that document the following for all participants receiving case management:

1. The name and Medicaid identification number of the participant.

2. Dates of the case management services.

3. The name of the provider agency (if relevant) and the person providing the case management service.

4. The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.

5. Whether the participant has declined services in the care plan.

6. The need for, and occurrences of, coordination with other case managers.

7. The timeline for obtaining needed services.

8. A timeline for reevaluation of the plan.

J. Limitations:

1. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

2. Case Management does not include, and FFP is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements, recruiting or interviewing potential foster care parents; serving legal papers, home investigation, providing transportation; administering foster care subsidies; making placement arrangements.

3. FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

Reserve for future use

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Reimbursement Methodology for HIV targeted Case Management Services

1. Effective for services on or after February 1, 2012, HIV targeted case management, including diagnostic evaluation services (DES) and ongoing case management services are paid as outlined in the MD fee-for-service schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners. Fee schedule and any annual/periodic adjustments to the fee schedule are published on the MD website at the following web address:

   http://www.dhmh.md.gov/mma/providerinfo/pdf/2011/Physicians_FeeSchedule_2011_2.pdf

2. HIV targeted case management services rendered shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene, 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 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.

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