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State/Territory Name: Maryland

State Plan Amendment (SPA) #: 13-09

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

SWIFT #062120134052

DEC 0 2 2013

Charles J. Milligan Jr.
Deputy Secretary
Health Care Financing
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Mr. Milligan:

Enclosed is a copy of the approved State Plan Amendment (SPA), Transmittal Number 13-09. This SPA is to update Targeted Case Management Services for people with intellectual and developmental disabilities transitioning to the community, in accordance with CMS guidance on services provided to this population.

The effective date for this amendment is July 1, 2013. The signed CMS-179 form and the approved State Plan pages are enclosed.

If you have questions about this SPA, please contact Lieutenant Commander Andrea Cunningham of my staff at (215) 861-4325.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosure

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	1. TRANSMITTAL NUMBER: 13-09	2. STATE Maryland
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	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 July 1, 2013	

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:	7. FEDERAL BUDGET IMPACT:
None	a. FFY 2013: $ 0 b. FFY 2014: $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 7 to Att. 3.1A, pages ~~8-15~~ 8-14 (95-15) ASC Attachment 4.19B, page 43 (NEW)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 7 to Att. 3.1A Pages ~~8 (95-15)~~ ASC 8-14 (95-15) ~~Att. 4.19B (NEW)~~ ASC

10. SUBJECT OF AMENDMENT:
To update DDA Resource Coordination Services, in accord with CMS guidance on services provided to three different populations.

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/	16. RETURN TO: Susan J. Tucker, Executive Director OHS – DHMH 201 W. Preston St., 1st floor Baltimore, MD 21201
13. TYPED NAME: Charles J. Milligan, Jr.	
14. TITLE: Deputy Secretary, Office of Health Care Financing	
15. DATE SUBMITTED: 6/6/13	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 7, 2013	18. DATE APPROVED: DEC 02 2013
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2013	20. SIGNATURE OF REGIONAL OFFICIAL: /S/
21. TYPED NAME: FRANCIS T. MCCULLOUGH	22. TITLE: ~~ASSOCIATE REGIONAL ADMINISTRATOR, DHHC~~

23. REMARKS:
Per Request of state officials, pen and ink changes to boxes 9 & 8 to reflect correct State plan page numbers, and box 15 to reflect correct date submitted.

FORM HCFA-179 (07-92)

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

Reimbursement Methodology for Targeted Case Management – Transitioning to the Community

1. Effective July 1, 2013, payments for Targeted Case Management Transition to the Community services as defined per Section 3.1A, Supplement 7 shall be paid based on a fee-for-service schedule. The rate can be found on the Developmental Disabilities website at http://dda.dhmh.maryland.gov/SitePages/Home.aspx and is the same for both governmental and private individual practitioners.

2. Comprehensive Assessment is reimbursed at a flat rate of $450.

3. For all other services, a "unit of service" means a 15 (fifteen) minute increment, reimbursed at $17.54 per unit for the transition year (7/1/13 – 6/30/14) and at $14.63 per unit thereafter.

4. The State assures that billed time does not exceed available productive time by practitioner.

5. Services can be provided by qualified professionals that meet the qualifications outlined in Section 3.1A, Supplement 7, §F. DDA Resource Coordination Staff Qualifications.

6. Limitations of fifteen minute increments for the following services unless otherwise pre- authorized by the DDA Director or designee:

   Transition Services - up to 208 units annually.

State Plan under Title XIX of the Social Security Act
State/Territory: Maryland

TARGETED CASE MANAGEMENT SERVICES FOR
People with intellectual and developmental disabilities
Transitioning to the Community

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Services shall be provided to participants who are:

1) Individuals who apply for services from the Developmental Disabilities Administration (DDA) and
2) Individuals who are found eligible for funding from the DDA and are:
    a. Transitioning to the community

_X_ The target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL, July 25, 2000)).

B. Areas of State in which Services Will Be Provided (§1915(g)(1) of the Act):

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

C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1))

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

D. Definition of Services (42 CFR 440.169)

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
    - Taking client history;
    - Identifying the individual's needs and completing related documentation; and

- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  The initial comprehensive assessment will be completed when the individual initially seeks services. Periodic reassessment of the individual's needs are conducted minimally annually during the annual Individual Plan meeting or more frequently based on the needs of the person;

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of eligible individuals;
- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable or providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities:
  - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family member, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - Services are being furnished in accordance with the individual's care plan;
    - Services in the care plan are adequate; and
    - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow up activities include making necessary adjustment in the care plan and services arrangement with providers.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the individual access services, identifying needs and supports to assist the eligible individual in obtaining

services; providing case managers with useful feedback, and alerting case managers to changes in the eligible person's needs. (42 CRF 440.169(e)).

E. Qualifications for Providers (42 CFR 441.18(a)(8)(V) and 42 CFR 441.18(b))
Provider agencies are licensed agents responsible for providing targeted case management to people eligible for funding from the Developmental Disabilities Administration (DDA). Licensed Case Management providers will include private providers and/or local health departments. The DDA will license a limited number of private case management providers in each region in addition to the local Health Departments. As a designated target group the State is choosing to limit the number of providers. By limiting providers, the State is able to improve oversight and ensure quality of services while offering more choice of providers.

In the event the solicitation process does not meet a sufficient number of providers, the DDA will conduct another interest meeting within six months of implementation. In the event licensed providers fail to continue to meet the qualifications, the DDA will conduct interest meetings to provide opportunities for new Case Management agencies to submit an application to become a DDA licensed Case Management provider to maintain the choice of providers.

At a minimum, prior to becoming a licensed provider, potential providers of Case Management services must:

1. Be incorporated in the State unless operating as a local health department;
2. Have a board of directors or local advisory board in accordance with the regulations;
3. Must attend a DDA single point of entry session and have submitted and have approved by DDA a:
    a) Business Plan which demonstrates fiscal viability;
    b) Program Service Plan to include scope of work and proposed staffing plan; and including staff and staff to participant ratios; and
    c) Formal written Policies and Procedures; and
    d) Formal written Quality Assurance Plan; and
    e) Documentation of strategies for locating community-based public, private, and generic resources; and
    f) Prior licensing reports issued within the previous ten years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records;
    g) Complies with all State and Federal statutes and regulations.
4. Be enrolled as a Medicaid provider and meet all the conditions for participation as set forth in regulations.

Private DDA licensed Case Management providers must:

1. Refrain from providing direct services to people receiving funding within the DDA service delivery system for Residential, Vocational, Day or Family or Individual Support Services;
2. Refrain from providing case management services to any persons receiving direct services from a parent company, subsidiary, or otherwise affiliated company; and
3. Provide resource coordination in all areas of the region.

All DDA licensed Case Management providers (including Local Health Departments) must:

1. Manage an electronic information system that has the capacity to maintain confidential individual case and billing records which provides documentation of case management services and number of units provided for individuals receiving services;
2. Maintain a standard 8-hour operational day Monday through Friday and have flexible staffing hours that include nights and weekends to accommodate the needs of individuals receiving services;
3. Have a means for individuals, their families, community providers, and DDA staff to contact the case management designated staff directly in the event of an emergency and at times other than at standard operating hours;
4. Maintain a toll free number unless otherwise authorized by the DDA and communication system accessible for everyone receiving Case Management services;
5. Be knowledgeable of the eligibility requirements, application procedures, and scope of services of federal, State, and local government assistance programs which are applicable to participants;
6. Have a management team with at least three (3) years experience each providing case management services or management experience in human services;
7. Have no legal sanctions or judgments within the past ten (10) years.

F. DDA Case Management Staff Qualifications:

Case Management Supervisor

The Case Management supervisor is an individual who is employed to provide oversight of case management services rendered and performance of case managers, and who has:

1. An advanced degree in human services and one (1) year experience or a Bachelor's degree in human services with three (3) years experience; except for Case Management Supervisors employed for a minimum of one (1) year by January 1, 2014 with an existing DDA licensed Case Management agency can be grandfathered as a qualified Case Management Supervisor in lieu of education requirement noted above.
2. Experience in any one or more of the following:
    a. Coordinating services for people in Medicaid and/or waiver programs
    b. Coordinating services for people with Intellectual/Developmental Disabilities
3. Demonstrated skills and working knowledge in:

a. Social services intake and referral services;
b. Data collection, analysis, and reporting;
c. Staff supervision; and
d. Management or leadership

4. Supervised the work of case managers
5. Monitored the quality of services provided

Case Manager

A Case Manager is an individual employed by the case management agency to assist authorized individuals in selecting and obtaining the most responsive and appropriate services and supports, and who meet the following criteria:

1. Has, at minimum, a Bachelor's degree in a human services field; except for Case Managers employed for a minimum of one (1) year by January 1, 2014 with an existing DDA licensed Case Management agency can be grandfathered as a qualified Case Manager in lieu of education requirements noted above.
2. Uses all communication methodologies, strategies, devices and techniques necessary, including sign language, assistive technology, or language interpreter services, to facilitate the involvement of the participant in the assessment, development, and monitoring of services and supports;
3. Ensure that each individual receives an individual plan that is designed to meet the individual's needs and in the most cost effective manner; and
4. Annually advise participants of their right to choose among qualified providers of services to include case managers.

G. Staff Training Requirements

1. All DDA licensed Case Management providers must ensure through appropriate documentation that Case Management staff receives training in person-directed supports focusing on outcomes as required by DDA.
2. All DDA licensed Case Management provider supervisors shall receive training in the following:
   a. Data collection, analysis and reporting; and
   b. Coaching, mentoring, and feedback skills; and
   c. Creative problem solving and conflict resolution.
3. All case management staff shall receive re-training as required by the DDA.

H. Freedom of Choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b))

_X_ Target group consists of eligible participants with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that participants with developmental disabilities or with chronic mental illness receive needed services.

As a designated target group the State is choosing to limit the number of providers. By limiting providers, the State is able to improve oversight and ensure quality of services while offering more choice of providers.

I. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3) and 42 CFR 441.18(a)(6))

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict a person's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

J. Payment (42 CFR 441.18(a)(4))
Payment for DDA Care Management services under the plan does not duplicate payments made to public agencies or private entities under other program authorizes for this same purpose.

K. Case Records (42 CFR 442.18(a)(7))
Providers maintain case records that document for all individuals receiving case management services as follows: (i) the name of the individual; (ii) the dates of the Case Management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; (viii) a timeline for reevaluation of the plan.

L. Limitations

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).

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

An additional limitation for specific service areas is as follows, unless otherwise authorized by the DDA:

a. Transition services: up to 208 hours annually