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State/Territory Name: Maryland

State Plan Amendment (SPA) #: 14-07

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# 042420144010

SEP 18 2014

Chuck Lehman, Interim Deputy Secretary
Health Care Financing
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Mr. Lehman:

Enclosed is a copy of the approved State Plan Amendment (SPA), Transmittal Number 14-07. This SPA updates Maryland's State Plan regarding Adult and Children's Targeted Case Management.

The effective date for this amendment is October 1, 2014. The 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

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 14-07

2. STATE: Maryland

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

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

4. PROPOSED EFFECTIVE DATE
October 1st, 2014

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
N/A

7. FEDERAL BUDGET IMPACT:
a. FFY 2014: $ 0
b. FFY 2015: $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B pg 15 ASC
Supplement to 3.1A, pg 8- 10-1-F
Supplement 3.1A, ~~10I-10X (NEW)~~ MC pg 10-G-10-W (NEW)
Att 4.19B, pg ~~16B (NEW)~~ ASC 15A (NEW

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement to 3.1A, pg 8- 10-1
Attachment 4.19B pg 15

10. SUBJECT OF AMENDMENT: 14-07 updates Maryland's State plan regarding Adult and Children's Targeted Case Management. Adult TCM SPA has only minor edits which limit participation to adults. The children's TCM SPA is new and creates a set of targeted case management services specifically for children and youth through age 21. The most significant changes from the adult TCM program which was used as a base is using 15-minute units of service, 3 levels of care, and specifying the role of the care coordination organization in managing the plan of care for 1915(i) participants. There are also updates to revise the rates for kids' TCM services to reflect the change to 15 minute units of service.

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

12. SIGNATURE OF STATE ~~AGENCY~~ OFFICIAL:
/S/

13. TYPED NAME: Charles Lehman

14. TITLE: Deputy Secretary,
Office of Health Care Financing

15. DATE SUBMITTED: 4/18/14

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 4/18/14

18. DATE APPROVED: SEP 18 2014

PLAN APPROVED – ~~ONE COPY ATTACHED~~

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME:
FRANCIS T. MCCULLOUGH

22. TITLE:
Associate Regional Administrator, DAMCHO

23. REMARKS: Per the request of Maryland Medicaid Officials, Pen and Ink changes were made to the following:
Boxes 8 & 9 were update to reflect changes and additions to the SPA submission.

FORM HCFA-179 (07-92)

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

TARGETED CASE MANAGEMENT SERVICES:
Individuals with Serious Mental Health Disorders

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

A beneficiary is eligible for mental health case management services if the beneficiary:

1) Adults, age 18 and over, who have a serious mental health disorder, diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Department, and who:

   a) Are at risk of or need continued community treatment, to prevent inpatient psychiatric treatment;

   b) Are elderly individuals, or young adults ages 18 through 21 who have been discharged from inpatient treatment in an Institution for Mental Disease;

   c) Are at risk of, or need continued community treatment to prevent being homeless; or

   d) Are at risk of incarceration or recently released from a detention center or prison.

2) All participants must meet at least one of the following conditions:

   a) The participant is not linked to mental health and medical services;

   b) The participant lacks basic supports for shelter, food, and income;

   c) The participant is transitioning from on level of care to another level of care; or

   d) The participant needs case management services to maintain community-based treatment and services.

3) The Department or its designee will authorize service delivery level based on the participants' needs.

_X_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to **30** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

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

_X_ Entire State

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TARGETED CASE MANAGEMENT SERVICES:
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___ Only in the following geographic areas:

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

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

D. Definition of Services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. The unit of service is one day, with a minimum of 1 hour per day of contact, which may include face-to-face contacts with a participant, and non-face-to-face contacts on behalf of the participant with nonparticipants, that are directly related to identifying the needs and supports for helping the individual to access services. The maximum service limit is 5 units per month, which may be exceeded based on clinical review by the Department or its designee. This includes all TCM activities, with the exception of the assessment, which uses a unit of service of one assessment and is billed separately.

Targeted Case Management includes the following assistance:

1) Comprehensive Assessment and Periodic Reassessment
   A community support specialist conducts a comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:

   a) Taking client history;
   b) Identification of the participant's stated needs and review of information concerning a participant's mental health, social, familial, cultural, medical, developmental, legal, vocational, and economic status to assist in the formulation of a care plan;
   c) Input from the participant, family members, and friends of the participant, as appropriate, and community service providers such as mental health providers, medical providers, social workers, and educators (if necessary) to form an assessment of the service needs of the participant;
   d) A required home visit by the community support specialist or community support specialist associate; and
   e) Reassessment to occur at least every six months.

2) Development (and Periodic Revision) of a Specific Care Plan
   a) Case management providers shall develop and periodically revise plans of care for each participant, based on the information collected through the assessment, that:

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i. Specifies the goals and actions to address the medical, mental health, social, educational, and other services needed by the individual;
ii. Includes activities such as ensuring the active participation and agreement of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
iii. Identifies a course of action to respond to the assessed goals and needs of the eligible individual.

b) The care plan shall be updated in conjunction with the participant's schedule for reassessments, to ensure that all services being provided remain sufficient. The participant, the participant's family, and any other significant others, with the participant's consent, shall participate with the community support specialist, to the extent practicable, in the development and regular updating of the participant's care plan.

c) The care planning process promotes consistent, coordinated, and timely service provision.

d) Care planning may include, as necessary and appropriate:
i. The care planning meeting, which includes the participant and with the participant's consent, providers, family members, other interested persons, as appropriate, for the purpose of establishing, coordinating, revising, and reviewing the care plan;
ii. The development and periodic updating of the written individualized care plan based on the participant's needs, progress, and stated goals; and
iii. Transitional care planning that involves contact with the participant or the staff of a referring agency or a service provider who is responsible to plan for continuity of care from inpatient level of care or an out of home placement to another type of community service.

3) Referral and Related Activities.
a) Community support specialist associates, under the direction of community support specialists, shall assure that the participant has applied for, has access to, and is receiving the necessary services. These services will be those that contribute to meeting the participant's needs and achieving goals as specified in the care plan, such as mental health, medical, social, or educational providers, resource procurement, transportation, or crisis intervention. This may include:
i. Scheduling appointments for the participant to help the eligible individual obtain needed services;
ii. Community support development by contacting, with the participant's consent, members of the participant's support network,

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including, family friends, and neighbors, as appropriate, to mobilize assistance for the participant;

iii. Crisis intervention by referral on an emergency basis when immediate intervention is necessary;
iv. Linking the participant to transportation to and from services;
v. Outreach in an attempt to locate service providers which can meet the participant's needs; and
vi. Reviewing the care plan with the participant and with the participant's consent, the participant's family and friends, as appropriate, in order to facilitate their participation in the care plan's implementation

4) Monitoring and Follow-up Activities:
   a) Monitoring and follow-up activities and contacts necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs. These activities may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one assessment every six months to determine whether the following conditions are met:
      i. Services are being furnished in accordance with the individual's care plan;
      ii. Services in the care plan are adequate; and
      iii. Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
   b) Engage in ongoing interaction with the participant, and, with the participant's consent, the participant's family and friends as appropriate and service providers.
   c) Follow up after service referral and monitor service provision on an ongoing basis, to ensure that the agreed-upon services are provided, are adequate in quantity and quality, and meet the participant's needs and stated goals; and
   d) Advocacy including:
      i. Empower the participant to secure needed services
      ii. Take any necessary actions to secure services on the participant's behalf; and
      iii. Encourage and facilitate the participant's informed decision making and choices leading to accomplishment of the participant's goals.
   e) The care plan may be revised to reflect changing needs identified from the service monitoring.

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

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

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)): The local mental health authority, called core service agencies (CSA), are agents of the county government who are responsible for planning and coordinating mental health services at the local level. Case management providers currently under contract with a CSA shall be approved to provide case management services until the end of their existing contract. Thereafter, at least once every five years, CSAs shall develop request for proposals (RFP) for mental health case management programs with experience serving individuals with serious mental illness or emotional disorders through the public mental health system. Case Management services may be provided by local health departments unless the Director of the MHA and the county health officer determine that the provision of case management services would be preferable to be delivered by a private vendor

Qualified provider agencies of case management shall be: 1) approved or licensed in Maryland as a community mental health program under Mental Hygiene Administration's community mental health regulations or have three years experience providing mental health case management services, and 2) have at least 3 years experience providing services to individuals with serious mental illness A case management provider agency willing to furnish case management services to the target population submits an application to the Department in order to demonstrate compliance with case management regulations, including provider qualifications. The Department reviews the application, and, if warranted, approves the provider agency as a mental health case management program.

Before a participant receives case management services, the Department's Mental Hygiene Administration's (MHA) Administrative Services Organization (ASO) reviews the authorization request, determines if the participant is meets medical necessity criteria, and if the participant meets the criteria, the participant is authorized for case management services. The participant has the option to choose from a variety of case managers hired by the case management program.

1) General requirements for the participation in the Program are that a case management program shall be enrolled as a Medicaid provider and meet all the conditions for participation as set forth in the Code of Maryland Regulations (COMAR) regarding conditions for provider participation in the Maryland Medical Assistance Program.. These regulations describe the condition to participate in the Program, and that the provider shall comply and ensure compliance with all the Medical Assistance provisions listed in COMAR designated for their provider type.

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2) Specific requirements for participation in the Program as a mental health case management program include all of the following:

a) Place no restriction on the qualified participant's right to elect to or decline to:
   i. Receive mental health case management services as authorized by the Department or the Department's designee; or
   ii. Choose a community support specialist or associate as approved by the Department or the Department's designee.

b) Employ appropriately qualified individuals as community support specialists and community support specialist associates with relevant work experience, including experience with the population served by the program, including but not limited to Adults with serious and persistent mental disorders.

c) Assure that a participant's initial assessment shall be completed within 20 days after the participant has been authorized by the ASO and determined eligible for, and has elected to receive, mental health case management services. An initial care plan shall be completed within 10 days after completion of the initial assessment.

d) Maintain a file for each participant which includes all of the following:
   i. An initial referral and intake form with identifying information;
   ii. A written agreement for services signed by the participant or the participant's legally authorized representative and by the participant's community support specialist;
   iii. An assessment, documented according to the Administration's requirements;
   iv. A care plan, updated, at a minimum of every six months, which contains at a minimum:
      (1) A description of the participant's strengths and needs;
      (2) The diagnosis established as evidence of the participant's eligibility for services under this chapter;
      (3) The goals of the community support services, with expected target dates;
      (4) The proposed intervention;
      (5) Designation of the community support specialist with primary responsibility for implementation of the care plan; and
      (6) Signatures of the community support specialist, participant or the participant's legally authorized representative, and significant others if appropriate.
   v. An ongoing record of contacts made in the participant's behalf, which includes all of the following:
      (1) Date and subject of contact;
      (2) Individual contacted;
      (3) Signature of community support specialist or community support specialist associate making the contact;
      (4) Nature, content, and unit or units of service provided;
      (5) Place of service;

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(6) Whether goals specified in the care plan have been achieved; and
(7) The timeline for obtaining needed services.

vi. Monthly summary notes, which reflect progress made towards the participant's stated goals.

e) Have formal written policies and procedures, approved by the Department, which specifically address the provision of mental health case management services to participants in accordance with these requirements;

f) Be available to participants and, as appropriate, the participant's families for 24 hours a day, 7 days a week in order to refer participants to needed services and supports and in a psychiatric emergency, to refer to mental health treatment and evaluation services in order to prevent the participant from accessing a higher level of care;

g) Participants may decline case management services. This will be documented in the participant's case management record;

h) Designate specific qualified staff to provide mental health case management services that shall include at least on community support specialist per agency and also may include a community support specialist associate;

i. Community support specialist means an individual who is employed by the case management program to provide case management services to participants, is chosen as the case manager by the participant or the participant's legally authorized representative, and has at least a:
(1) Bachelor's degree in a mental health field and 1 year of mental health experience including mental health peer support, or
(2) Bachelor's degree in a field other than mental health and 2 years of mental health experience including a mental health peer support.

ii. Community support specialist associate means an individual who is employed by the case management program to assist community support specialists in the provision of mental health case management services to participants, work under the supervision of a community support specialist who delegates specific tasks to the associate, and has at least a high school degree or the equivalent, and 2 years of experience with individuals with mental illness including mental health peer support.

iii. Community support specialist supervisor means an individual who is employed or contracted to supervise case management services at

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a ratio of one supervisor for every eight community support specialists or associates; who provides clinical oversight of assessments and case management services rendered, and consultation and training to community support specialists and community support specialist associates regarding mental illness; who provides some direct case management services; and who is a mental health professional who is authorized and licensed under Maryland Practice Boards in the profession of Social Work, Professional Counseling, Psychology, Nursing, Occupational Therapy, or Medicine; and has one year experience in mental health working as a supervisor.

i) Refrain from providing other services to participants which would be viewed by the Department as a conflict of interest;

j) Be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs which are applicable to participants;

k) Maintain information on current resources for mental health, medical, social, financial assistance, vocational, educational, housing, and other support services;

l) Safeguard the confidentiality of the participant's records in accordance with State and federal laws and regulations governing confidentiality;

m) Comply with the requirements for the delivery of mental health services outlined by the department.

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

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

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
_X_ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: Providers must be selected through a competitive procurement process by the local Core Service Agency, in accordance with the 1915(b)(4) waiver. This process will ensure that every jurisdiction

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TARGETED CASE MANAGEMENT SERVICES:
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in the State is adequately prepared to offer high-quality, comprehensive case management services to eligible individuals.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

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

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs. This includes services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents;

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serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

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

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TARGETED CASE MANAGEMENT SERVICES: Care Coordination for Children and Youth

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

A participant is eligible for care coordination services if the recipient:

Is in a federal eligibility category for Maryland Medical Assistance, which governs the determination of eligibility for the Maryland Medical Assistance Program. Services shall be provided to participants who are:

(1) Children and adolescents under 18 years with a serious emotional disturbance, or co-occurring mental health and substance use disorders diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary;

OR

(2) Young adults with a serious emotional disturbance or co-occurring disorder diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary, who have been enrolled in case management services continuously since reaching age 18, and who require community treatment and support in order to prevent or address:

(a) Inpatient psychiatric or substance use treatment;

(b) Treatment in a residential treatment center (RTC);

(c) Treatment in a residential substance use treatment facility;

(d) An out-of-home placement;

(e) Emergency room utilization due to multiple behavioral health stressors;

(f) Homelessness or housing instability, including doubling up, or otherwise lacking in permanent, safe housing;

(g) Arrest or incarceration due to multiple behavioral health stressors; and/or

(h) Needs case management services to facilitate community treatment following:

(i) Release from a detention center or correctional facility; or
(ii) Discharge to the community from RTC placement or inpatient psychiatric unit.

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TARGETED CASE MANAGEMENT SERVICES:
Care Coordination for Children and Youth

(3) Participants must additionally meet at least two of the following conditions:

(a) The participant is not linked to behavioral health, health insurance, or medical services;

(b) The participant lacks basic supports for education, income, shelter, and food;

(c) The participant is transitioning from one level of intensity to another level of intensity including transitions out of the following levels of service:
  (i) Inpatient psychiatric or substance use services;
  (ii) Residential treatment center;
  (iii) Any service specified in section 1915(i) of Maryland's State Plan.

(d) The participant needs care coordination services to obtain and maintain community-based treatment and services;

(e) The participant has a history of psychiatric hospitalizations or a history of repeated visits or admissions to emergency room psychiatric units, crisis beds, or inpatient psychiatric units due to multiple behavioral health stressors within the past 12 months; or

(f) The participant is enrolled in Maryland's 1915(i) program.

(4) Participants that decline services after reaching 18 years of age must re-enter case management services within 120 days to maintain eligibility

_X_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to **30** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State
___ Only in the following geographic areas

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

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TARGETED CASE MANAGEMENT SERVICES:
Care Coordination for Children and Youth

B. Definition of services (42 CFR 440.169):
Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Units of service are 15 minutes of contact, which may include face-to-face and non-face-to-face contacts with the participant or, if the participant is a minor, with the minor's parent or guardian; and indirect collateral contacts on behalf of the participant with other community providers. The maximum service limit is 60 units per month, which may be exceeded based on clinical review by the Department or its designee.

Targeted Case Management includes the following assistance:

(1) Comprehensive participant assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services, using the child and youth assessment tools designated by the Department.

(a) Initial assessment or reassessment involves the taking the client history, identifying the individual's needs, and reviewing information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual. This information may relate to the participant's mental health, social, familial, educational, cultural, medical, developmental, legal, vocational, and economic status to assist in the formulation of a Plan of Care (POC).

(b) The initial assessment or reassessment of the participant's needs and progress is facilitated by the care coordinator in partnership with a team, which includes the participant, family members, and friends of the participant, as appropriate, or, if the participant is a minor, the minor's parent or guardian, and community service providers, such as mental health providers, medical providers, social workers, and educators, as appropriate.

(c) Coordination and facilitation of the team:
(i) Identification of a location for the meeting that is suitable to the participant's needs;
(ii) Convened at least every six months, or more frequently, as clinically necessary or indicated by the plan of care;

(d) After an initial assessment, each participant shall be reassessed at a minimum of every six months.

(2) Development (and Periodic Revision) of a Specified Plan of Care

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TARGETED CASE MANAGEMENT SERVICES: Care Coordination for Children and Youth

(a) After the initial assessment is completed, a POC shall be developed based on the information obtained through the comprehensive screening and assessment tools approved by the Department.

(b) The Care Coordination Organization shall finalize the POC within 30 calendar days of notification of enrollment and submit it to the Department or its designee.

(c) Development of and updates to the POC will be youth and family-directed and managed through team meetings.

(d) The POC development process includes:

(i) The team meeting, which includes the participant, and if the participant is a minor, the minor's parent or guardian, providers, family members, other interested persons, as appropriate, for the purpose of establishing, revising, and reviewing the POC;

(ii) The development of the written, individualized POC based on the participant's strengths, needs, and progress toward outcome measures;

(iii) Transitional care planning that involves contact with the participant or, if the participant is a minor, the minor's parent or guardian, or the staff of a referring agency, or a service provider who is responsible to plan for continuity of care from inpatient level of care or an out-of-home placement to another type of community service; and

(iv) Discharge planning from care coordination, when appropriate and when the family is closer to their identified vision, needs have been met, and outcome measures achieved for care coordination have been achieved.

(e) After the POC is developed, it shall be updated as often as clinically indicated based on the strengths and needs of the participant but in no instance less than every six months, and within seven days following a crisis event.

(f) Requirements of the POC. The POC shall contain, at minimum:

(i) A description of the participant's strengths and needs;

(ii) The diagnosis(es) established as evidence of the participant's eligibility for services under this chapter;

(iii) The goals of care coordination services to address the behavioral health, medical, social, educational, and other services needed by the participant, with expected target completion dates and proposed course of action;

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(iv) A crisis plan including the proposed strategies and interventions for preventing and responding to crises and the youth and family's definitions of what constitutes a crisis;

(v) Designation of the care coordinator with primary responsibility for implementation of the POC;

(vi) Signatures of the care coordinator and other team members, if appropriate;

(vii) Signatures of the participant and family indicating that the participant and family has actively participated in the development of the POC, had choice in the selection of services, providers, and interventions, when possible;

(viii) An ongoing record of contacts made on the participant's behalf; and

(ix) The following details for each recommended service the following Information, as appropriate:
   a. Description of the service;
   b. Service start date;
   c. Estimated duration;
   d. Frequency and units of service to be delivered;
   e. The specific need or goal that the service is related to; and,
   f. The provider name and contact information.

(g) The CCO shall facilitate team meetings to review and update the POC, which includes the following duties:

(i) Coordinate and facilitate the team, with team meetings convened at least every 45 days or more frequently as clinically indicated;

(ii) Record and keep notes at every team meeting that include the team members who were present, a summary of the discussion, any changes to the POC, and action items for follow up, and share them with the team members, including those who were not in attendance;

(iii) Update the POC to include change in progress, services, or other areas within five days of the team meeting;

(iv) Ensure that the care coordinator facilitates team meetings, access to the services and supports in the POC, administers the appropriate assessments, and works with the participant and family to develop an

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initial crisis plan that includes response to immediate service needs; and

(v) Provide an overview of the wraparound process for those enrolled in a wraparound model of services.

(3) Referral and Related Activities.
The care coordinator shall assure that the participant, or, if the participant is a minor, the minor's parent or guardian, has applied for, has access to, and is receiving the necessary services available to meet the participant's needs as specified in the POC, such as mental health services, resource procurement, transportation, or crisis intervention. The care coordinator shall take the necessary action when this has not occurred. The linkage process shall include:

(a) Community and natural support development by contacting, with the participant's consent, members of the participant's support network, including team members, for example, family, friends, and neighbors, as appropriate, or, if the participant is a minor, the minor's parent or guardian, to mobilize assistance for the participant;

(b) Crisis intervention by referral of the participant or, if the participant is a minor, the minor's parent or guardian, to services on an emergency basis when immediate intervention is necessary;

(c) Linking the participant to transportation to and from services;

(d) Outreach in an attempt to locate service providers which can meet the participant's needs, or, if the participant is a minor, the minor's parent or guardian's needs for the child or adolescent;

(e) Reviewing the POC with the participant and the participant's team, as appropriate, or, if the participant is a minor, with the minor's parent or guardian, so as to enable and facilitate their participation in the plan's implementation; and

(f) Providing linkages to health and wellness education, information, high-quality health care services, preventive and health promotion resources, and chronic disease management services with an emphasis on resources available in the family's community and peer group; and,

(4) Monitoring and Follow-up Activities

(a) A CCO shall monitor the activities and contacts that are considered necessary to ensure the POC is implemented and adequately addresses the participant's needs, and include:

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(i) The participant, or if the participant is a minor, the minor's parent or guardian;
(ii) With proper consent, family members and friends, if appropriate; and
(iii) Other individuals or agency representatives identified and approved as team members by the participant, or if the participant is a minor, the minor's parent or guardian; and
(iv) Other service providers, if any.

(b) The CCO shall:
(i) Follow up any service referral within seven days to determine whether the participant, or if the participant is a minor, the minor's parent or guardian made contact with the service provider that the participant was referred to; and
(ii) Monitor service provision on an ongoing basis, and including at least one annual monitoring, to ensure that the agreed-upon services are provided, are adequate in quantity and quality, and meet the participant's needs and stated goals, or, if the participant is a minor, the parent's or guardian's stated needs and goals for the participant.
(iii) Revise the POC to reflect the participant's changing needs.
(iv) Engage in participant advocacy, including:
i. Empowering the participant and, if the participant is a minor, the minor's parent or guardian, to secure needed services;
ii. Taking any necessary actions to secure services on the participant's behalf; and
iii. Encouraging and facilitating the participant's decision-making and choices leading to accomplishment of the participant's goals or, if the participant is a minor, encourage the parent or guardian to carry out these decisions.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

C. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
The local mental health authority, called core service agencies (CSA), are agents of county government who are responsible for planning and coordinating mental health services at the local level. CSAs shall select child and youth Care Coordination Organizations (CCOs)s through a competitive procurement process, at least once every five years. Regional CCOs may be procured at the mutual agreement of local core service CSA so long as the local CSAs demonstrate that there is sufficient provider capacity to serve the children and youth in a particular region. The CCO must demonstrate a minimum of three years of experience providing care coordination

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services. Once selected, the CCO shall be approved and commit to cording with all agencies involved in the participant's POC, including State and local child- and family-serving agencies to develop a network of clinical and natural supports in the community to address strengths and needs identified in each POC.

To be eligible to be approved as a care coordination organization, an entity shall meet all of the following:

(1) General requirements for participation in the Program are that a CCO shall be enrolled as Medicaid provider and meet all the conditions for participation as required by the state.

(2) Specific requirements for participation in the Program as CCO include all of the following:

(a) Place no restrictions on the participant's, or if the participant is under 18 years of age, the participant's parent or guardian's right to elect to or decline to:
  (i) Receive care coordination as authorized by the Department; and
  (ii) Choose a care coordinator, as approved by the Department, and other care providers.

(b) Employ appropriately qualified individuals as care coordinators, and care coordinator supervisors with relevant work experience, including experience with the populations of focus, including but not limited to:
  (i) Minors with a serious emotional disturbance or co-occurring disorder; and
  (ii) Youth with a serious emotional disturbance or co-occurring disorder.

(c) Shall assign care coordinators to the participant and family;

(d) Schedule a face-to-face meeting with the participant and family within 72 hours of notification of the participant's enrollment in Care Coordination services;

(e) Convene the first team meeting within 30 calendar days of notification of enrollment to develop the POC;

(f) Collect information gathered during the application process including results from the physical examination, psychosocial and psychiatric screening, assessments, evaluations, and information from the team, participant, family, and the identified supports to be incorporated as a part of POC development process;

(g) Arrange for the participant and family to meet with applicable providers to determine their role in development and implementation of the POC. This

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includes, for participants receiving services specified in section 1915(i) of Maryland's state plan:

(i) Arrange for the participant and family to meet with peer support partners within 30 days of notification of enrollment to allow the participant and family the opportunity to determine the role of peer support in the development and implementation of the POC;
(ii) Arrange for the participant and family to meet with the intensive in-home service (IIHS) and/or mobile crisis response service (MCRS) provider to develop the initial crisis plan within one week of enrollment in the 1915(i);

(h) Shall assure that:
(i) A participant's initial assessment is completed within 10 days after the participant has been authorized by Department and determined eligible for, and has elected to receive, care coordination services; and
(ii) An initial POC is completed within 15 days after completion of the initial assessment;

(i) Maintain an electronic health record for each participant which includes all of the following:
(i) An initial referral and intake form with identifying information, including, but not limited to, the individual's name and Medicaid identification number;
(ii) A written agreement for services signed by the participant or the participant's legally authorized representative and by the participant's care coordinator; and
(iii) An assessment as specified in Section D(1) above.
(iv) A POC as specified in Section D(3) above.

(j) Have formal written policies and procedures, approved by the Department, or the Department's designee, which specifically address the provision of care coordination to participants in accordance with the requirements of this chapter;

(k) Be available to participants and, as appropriate, their families or, if the participant is a minor, the minor's parent or guardian, for 24 hours a day, seven days a week in order to refer:
(i) Participants to needed services and supports; and
(ii) In the case of a behavioral health emergency, participants to behavioral health treatment and evaluation services in order to divert the participant's admission to a higher level of care;

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(l) Shall document in the participant's care coordination records if the participant declines care coordination services or if a service is terminated because it was not working;

(m) May not provide other services to participants that would be viewed by the Department as a conflict of interest;

(n) Shall be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs that are applicable to participants;

(o) Shall maintain information on current resources for behavioral health, medical, social, financial assistance, vocational, educational, housing, and other support services including informal community resources;

(p) Shall safeguard the confidentiality of the participant's records in accordance with State and federal laws and regulations governing confidentiality;

(q) Shall comply with the Department's fiscal and program reporting requirements and submit reports in the manner specified by the Department to the Department;

(r) Shall provide services in a manner consistent with the best interest of recipients and may not restrict an individual's access to other services;

(s) Shall assure the amount, duration, and scope of the care coordination activities are documented in a participant's POC, which includes care coordination activities before discharge and after discharge when transitioning from an institution, to facilitate a successful transition into the community; and

(t) Commit to coordinating with all agencies involved in the participant's POC.

(2) Designate specific qualified staff including:

(a) Care coordinator supervisor who:
(i) Is a mental health professional with a minimum of a Master's degree and who is licensed and legally authorized to practice under the Health Occupations Article, Annotated Code of Maryland, and who is licensed under Maryland Practice Boards in the profession of:
a. Social work;
b. Professional Counseling;
c. Psychology;

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d. Nursing; or
e. Medicine

(ii) Has a minimum of one year of experience in behavioral health working as a supervisor;

(iii) Has a minimum of one year of experience working with children and youth with mental health or co-occurring disorders;

(iv) Provides clinical consultation and training to care coordinators regarding mental health or co-occurring disorders;

(v) Provides supervision of the POCs, and consultation to the CFT meetings, as needed;

(vi) Is employed or contracted at a ratio of one supervisor to every eight care coordinators;

(vii) Meets training and certification requirements for care coordinator supervisors, as set by the Department.

(b) Care coordinator has at least a:

(i) Bachelor's degree and has met the Department's training requirements for care coordinators; or

(ii) A high school diploma or equivalency and

a. Is 21 years or older; and
b. Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who received services from the public and child- and family-serving system; and,
c. Meets the training and certification requirements for care coordinators as set forth by the Department.
d. Is employed by the CCO to provide care coordination services to participants; and
e. Provides management of the POC and facilitation of the CFT meetings.

(3) Required criminal background checks. The provider shall, at the provider's own expense and for all staff, volunteers, students, and any individual providing Care Coordination services to participants and their families:

(a) Before employment, submit an application for a child care criminal history record check to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services (DPSCS); and

(b) Request that DPSCS send the report to:

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

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

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(iii) Review the results of the background checks; and

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

(v) Maintain written documentation in the individual's personnel file that the director and all direct service provider staff including, but not limited to, volunteers, interns, and students, meet all requirements.

(4) Prohibitions against utilization of staff. The provider shall:

(a) Unless waived by the Department, prohibit from working with the participant or the participant's family any staff, volunteers, students, or any individual who is:

(i) Convicted of, received probation before judgment, or entered a plea of *nolo contendere* to a felony or a crime of moral turpitude or theft or have any other criminal history that indicates behavior which is potentially harmful to participant; or

(ii) Be cited on any professional licensing or certification boards or any other registries with a determination of abuse, misappropriation of property, financial exploitation, or neglect.

(iii) Has an indicated finding of child abuse or neglect.

(5) Waiver of Employment Prohibitions. The Department may waive the prohibition against working with the participant or the participant's family if the provider submits a request to the Department together with the following documentation that:

(a) For criminal background checks:

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

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

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

(b) For abuse and neglect findings:

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

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

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

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

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

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
_X_ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Providers must be selected through a competitive procurement process by the local Core Service Agency, in accordance with the State's 1915(b)(4) waiver. This process will ensure that every jurisdiction in the State is adequately prepared to offer high-quality, comprehensive case management services to eligible individuals.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

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

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case

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management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

4. Reimbursement Methodology for Mental Health Case Management

4a. Effective September 1, 2009, payments shall be made with the fee -for-service schedule for mental health case management services specified in 4e. This rate can he found on the Mental Hygiene Administration's website at: http://www.dbmh.state.mdus/mha/ratesschedule.html. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers.

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

a. Level 1 – General: A minimum of one and a maximum of two units of service each month. At a minimum, every 90 days, one service shall include a visit to the participant's home or another suitable site for a participant who is homeless.

b. Level II- Intensive: A minimum of two and a maximum of five units of service each month. At a minimum, every 90 days, one service shall include a visit to the participant's home or another suitable site for a participant who is homeless.

c. One additional unit of service above the monthly maximum may be billed during the first month of service to a participant in order to complete the comprehensive assessment.

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

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

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

4a. Effective, October 1, 2014, payment shall be made with the fee-for-service schedule mental health care management services specified in 4c. This rate can be found on the Mental Hygiene Administration's website at: http://dhmh.maryland.gov/mha/SitePages/infoforproviders.aspx Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers.

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

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

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

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