

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: 09-06	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 September 1, 2009
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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: a. FFY <u>2010</u> \$296,941 b. FFY <u>2011</u> \$3,607,827
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 3 to Attachment 3.1-A, Page 8-Page 10-I Attachment 4.19 A&B Page 55 Attachment 4.19 A Page 55-55A	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): Supplement 3 to Attachment 3.1-A, Page 8-Page 10-I (06-12) Attachment 4.19 A&B Page 55 (92-19) NEW
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10. SUBJECT OF AMENDMENT:  
Adding Case Management Services for individuals with serious mental illness and minors with serious emotional disorders.

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

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED: The Secretary of the  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Department of Health and Mental Hygiene  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Susan Tucker Executive Director Office of Health Services Department of Health & Mental Hygiene 201 W Preston St, 1 <sup>st</sup> floor Baltimore MD 21201
13. TYPED NAME: John M. Colmers	
14. TITLE: Secretary, Department of Health & Mental Hygiene	
15. DATE SUBMITTED:	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:	18. DATE APPROVED:
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PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

FEDERAL REGULATION CITATIONS: SPA 09-06

- \_\_\_ Attachment 2.2A 42 CFR 435.10
- \_\_\_ Attachment 2.6A 42 CFR Part 435, Section 435.10 and Subparts G&H AT-78-90, AT-80-6, AT-80-34, 1902(l) and (n) of the Act, P.L. 99-509 (Secs. 9401 and 9402), 1902 (l) and (n) and 1920 of the Act, P.L. 99-509 (Secs. 9401, 9402, and 9407)
- X Attachment 3.1A Part 400, Subpart B and 1902(e)(5), 1905(a)(18) through (20), and 1920 of the Act, P.L. 99-272 (Sections 9501, 9505 and 9526) and 1902(a), 1902(a)(47), 1902 (e)(7) through (9), and 1920 of the Act, P.L. 99-509 (Sections 9401(d), 9403, 9406 through 9408) and P.L. 99-514 (Section 1985(c)(3))
- \_\_\_ Attachment 3.1B 42 CFR Part 440, Subpart B, 42 CFR 441.15, AT-78-90, AT-80-34
- \_\_\_ Attachment 3.1C 42 CFR 431.53, AT-78-90
- \_\_\_ Attachment 3.1F 1905(a)(24) and 1930 of the Act, P.L. 101-508 (Section 4712 OBRA 90)
- \_\_\_ Attachment 4.18A 447.51 through 447.58
- \_\_\_ Attachment 4.18C 447.51 through 447.58
- \_\_\_ Attachment 4.18-F 447.50-447.59
- X Attachment 4.19 A&B (a) 42 CFR 447.252, 46 FR 44964, 48 FR 56046, 50 FR 23009, 1902(e)(7) of the Act, P.L. 99-509 (Section 9401(d))
- (b) 42 CFR 447.201, 42 CFR 447.302, AT-78-90, AT-80-34, 1903(a)(1) and (n) and 1920 of the Act, P.L. 99-509 (Section 9403, 9406 and 9407), 52 FR 28648
- \_\_\_ Attachment 4.16 42 CFR 431.615(c) AT-78-90
- \_\_\_ Attachment 4.19D (d) 42 CFR 447.252, 47 FR 47964, 48 FR 56046, 42 CFR 447.280, 47 FR 31518, 52 FR 28141
- \_\_\_ Attachment 4.22A (a) 433.137( a), 50 FR 46652, 55 FR 1423
- \_\_\_ Attachment 4.22B (b) 433.138(f), 52 FR 5967, 433.138(g)(1)(ii) and (2)(ii), 52 FR 5967, 433.133(g)(3)(i) and (iii), 52 FR 5967, 433.138(h)(4)(i) through (iii), 52 FR 5967
- \_\_\_ Attachment 4.22C Section 1906 of the Act
- \_\_\_ Attachment 4.26 1927(g) 42 CFR 456.700, 1927(g)(1)(A), 1927(g)(1)(a) 42 CFR 456.705(b) and 456.709(b), 1927(g)(1)(B) 42 CFR 456.703(d) and (f), 1927(g)(1)(D) 42 CFR 456.703(b), 1927(g)(2)(A) 42 CFR 456.705(b), 1927(g)(2)(A)(i) 42 CFR 456.705(b), 1927(g)(2)(A)(i) 42 CFR 456.705(b), (1)-(7), 1927(g)(2)(A)(ii) 42 CFR 456.705(c) and (d), 1927(g)(2)(B) 42 CFR 456.709(a), 1927(g)(2)(C) 42 CFR 456.709(b), 1927(g)(2)(D) 42 CFR 456.711, 1927 (g)(3)(A) 42 CFR 456.716(a), 1927 (g)(3)(B) 42 CFR 456.716 (A) and (B), 1927(g)(3)(C) 42 CFR 456.716 (d) 1927(g)(3)(C) 42 CFR 456.711 (a)-(d), 1927 (g)(3)(D) 42 CFR 456.712 (A) and (B), 1927(b)(1) 42 CFR 456.722, 1927(g)(2)(A)(i) 42 CFR 456.705(b), 1927(j)(2) 42 CFR 456.703(c)
- \_\_\_ Attachment 4.32A (a) 435.940 through 435.960, 52 FR 5967
- \_\_\_ Attachment 4.33A (a) 1902(a)(48) of the Act, P.L. 99-570 (Section 11005), P.L. 100-93 (Section 6(a)(3))
- \_\_\_ Attachment 4.35A (a) 1919(b)(1) and (2) of the Act, P.L. 100-103 (Section 4212(a))
- \_\_\_ Attachment 4.35B (b) Same as above

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**CASE MANAGEMENT SERVICES**  
**FOR Individuals with serious mental illness and minors with serious emotional disorders**

**A. Target Group:**

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

Is in a federal eligibility category for and is enrolled in the Maryland Medical Assistance Program according to COMAR 10.09.24. These regulations govern the determination of eligibility for the Maryland Medical Assistance Program. Services shall be provided to participants who are:

- 1) Children and adolescents, referred to as minors, with serious emotional disorders diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary and is in, or at risk of, or needs continued community treatment to prevent:
  - a) Inpatient psychiatric treatment;
  - b) Treatment in a Residential Treatment Center (RTC); or
  - c) An out of home placement due to multiple mental health stressors.

OR

- 2) Adults who have a serious and persistent mental health disorder, diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary, and who:
  - a) Are in, are at risk of, or need continued community treatment to prevent inpatient psychiatric treatment;
  - b) Are at risk of, or need continued community treatment to prevent being homeless; or
  - c) Are at risk of incarceration or will be released from a detention center or prison.

iii. The specific diagnostic criteria may be waived for the following two conditions:

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- a. An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland; or
  - b. An individual in a Mental Hygiene Administration facility or a Mental Hygiene Administration funded inpatient psychiatric hospital who requires community services. This excludes individuals eligible for Developmental Disabilities Administration's residential services.
- iv. Participants shall meet the above requirements and be classified according to the following levels of service:
- a. Level I – General: For a maximum of 2 units of service per month and based on the severity of the participant's mental illness, the participant must meet at least one of the following conditions:
    - i. The participant is not linked to mental health and medical services;
    - ii. The participant lacks basic supports for shelter, food, and income;
    - iii. The participant is transitioning from one level of care to another level of care; or
    - iv. The participant needs case management services to maintain community-based treatment and services.
  - b. Level II – Intensive: For a maximum of 5 units of service per month and based on the severity of the participant's mental illness, the participant must meet two or more of the following conditions:
    - i. The participant is not linked to mental health and medical services;
    - ii. The participant lacks basic supports for shelter, food, and income;
    - iii. The participant is transitioning from one level of care to another level of care; or
    - iv. The participant needs case management services to maintain community-based treatment and services.
- v. The target populations may include individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the institution.

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**B. Areas of State in which Services Will Be Provided:**

Entire State

Only in the following geographic areas (authority of 1915 (g) (1) of the Act is invoked to provide services less than statewide):

**C. Comparability of Services:**

Services are provided in accordance with 1902 (a) (10) (B) of the Act.

Services are not comparable in amount, duration and scope.  
Authority of 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of 1902 (a) (10) (B).

**D. Definition of Services:**

Case management services are provided to assist participants, eligible under the State Plan, in gaining access to needed medical, mental health, social, educational and other services. The Program shall reimburse for the following services under mental health case management when these services have been documented as necessary:

- 1) Comprehensive Assessment and Periodic Reassessment
  - a) Assessment or reassessment involves 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.
  - b) The assessment or reassessment of the participant's service needs is conducted by the community support specialist and incorporates input from 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 (if necessary) to form an assessment of the service needs of the participant.

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- c) A home visit by the community support specialist or community support specialist associate is required.
  - d) After an initial assessment, each participant shall be reassessed every six months.
- 2) Development (and Periodic Revision) of a Specific Care Plan
- a) After the initial assessment is completed, a care plan shall be developed. Every six months after that, 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, a legal guardian, the participant's family, and any significant others, with the participant's consent, or, if the participant is a minor, the minor's parent or guardian'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.

The specific care plan:

- i. Is developed with the participant and based on the assessment;
  - ii. Specifies the goals and actions to address the medical, mental health, social, educational, and other services needed by the participant;
  - iii. Includes the active participation and agreement of the participant, and/or the participant's authorized health care decision maker and others designated by the participant and for minors, a parent or guardian; and
  - iv. Identifies strategies to meet the goals and needs of the participant.
- b) The care planning process promotes consistent, coordinated, and timely service provision.
  - c) 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;
    - 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

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from inpatient level of care or an out of home placement to another type of community service; and

- iv. Discharge planning from mental health case management services, when appropriate, or when goals for case management have been achieved.
- d) Case management services are coordinated with and do not duplicate activities provided as part of institutional services and discharge planning activities.

3) Referral and Related Activities

a) Community support specialist associates, under the direction of community support specialists, 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 to meet the participant's needs, such as mental health and medical services, resource procurement, transportation, or crisis intervention. The community support specialist shall take the necessary action when this has not occurred.

b) Included in the referral process are:

- i. Community support development by contacting, with the participant's consent, members of the participant's support network, including, 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;
- ii. Crisis intervention by referral of the participant or, if the participant is a minor, the minor's parent or guardian, with services on an emergency basis when immediate intervention is necessary;
- iii. Arranging for the participant's transportation to and from services;
- iv. 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; and
- v. Reviewing the care plan with the participant and with the participant's consent, the participant's family and friends, as appropriate, or, if the participant is a minor the minor's parent or guardian, in order to facilitate their participation in the care plan's implementation.

4) Monitoring and Follow-up Activities

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- a) Monitoring and follow-up includes activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the participant's needs, and which may be with the participant, family members, 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 participant's care plan;
  - ii. Services in the care plan are adequate; and
  - iii. If the needs of the participant changes, and if applicable, make necessary adjustments to the care plan including referrals for services.
- b) Engage in ongoing interaction with the participant, and, with the participant's consent, the participant's family and friends as appropriate or, if the participant is a minor, the minor's parent or guardian, 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 or, if the participant is a minor, the parent's or guardian's needs and stated goals for the participant.
- d) The care plan may be revised to reflect changing needs identified from the service monitoring.
- e) Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.
- f) Advocacy including:
  - i. Empower the participant or, if the participant is a minor, the minor's parent or guardian, 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 or, if the participant is a minor, encourage the parent or guardian to carry out these decisions.

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**E. Qualification of Providers:**

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. 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.

Once selected, providers 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 or children and adolescents with emotional disorders including managing high risk populations. After the CSA selects a qualified case management provider, the selected case management provider submits an application to the Department in order to demonstrate compliance with case management regulations. The Department reviews the application, and, if warranted, approves the program 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 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 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 COMAR 10.09.36.03. 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 the Code of Maryland Regulations (COMAR) designated for their provider type.
- 2) Specific requirements for participation in the Program as a mental health case management program include all of the following:

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- a) Place no restrictions 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 populations served by the program, including but not limited to:
  - (1) Adults with serious and persistent mental disorder; and
  - (2) Children and adolescents with serious emotional disorders.
  
- c) Assure that:
  - i. 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; and
  - ii. 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 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.

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- 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;
    - (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.
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- 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 or, if the participant is a minor, the minor's parent or guardian, 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 one 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

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- (2) Bachelor's degree in a field other than mental health and 2 years of mental health experience including 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, works under the supervision of a community support specialist who delegates specific tasks to the associate, and has at least:
  - (1) 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 a ratio of one supervisor for every eight community support specialists or associates, and 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, and who is:
  - (1) 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 Department's fiscal reporting requirements and submit reports in the manner specified by the Department; and

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- n) Comply with the requirements for the delivery of mental health services outlined by the Department.

**F. Freedom of Choice:**

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

1. Eligible participants shall have free choice of the providers of case management services.
2. Eligible participants shall have free choice of the providers of other medical care under the care plan. In accordance with 1902(a) A (23) of the Act.

**Freedom of Choice Exception:**

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

**G. Access to Services:**

- 1) 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.
- 2) The State assures that participants will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.
- 3) The State assures that 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 which includes case management activities prior to and post-discharge, to facilitate a successful transition to the community.
- 5) The State assures that case management is only provided by and reimbursed to community case management providers.

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**H. Case Records:**

Providers maintain medical records that document for all participants receiving case management the following: the name and Medicaid identification number of the participant; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; whether the participant has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

**I. Limitations:**

Case Management does not include the following:

- 1) The direct delivery of an underlying medical, educational, social, or other service to which an eligible participant has been referred.
- 2) Activities integral to the administration of foster care programs;
- 3) Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act; and
- 4) Activities for which third parties are liable to pay.

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**Reimbursement Methodology for Mental Health Case Management**

1. Effective September 1, 2009, payments shall be made with the fee-for-service schedule for mental health case management services specified in #3. This rate can be found on the Mental Hygiene Administration’s website at:  
<http://www.dhmh.state.md.us/mha/ratesschedule.html>.
  
2. “Unit of service” means one day of service with a face-to-face contact for a minimum of one hour per day by the community support specialist or the community support specialist associate with the participant or, if the participant is a minor, the minor’s parent or guardian. Services shall be provided according to the following:
  - a. Level I – General: A minimum of one and a maximum of two days 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 days 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.
  
3. Rate development - The following details the rate development for the mental health case management service. This follows the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs.

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**Mental Health Case Management Rate Development**

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\$36,000 community support specialist (CSS) salary  
\$60,000 clinical supervisor salary  
Clinical supervisor to CSS ration of 1:8

**Billable Time**

52 weeks x 40 hours	2,080
Vacation and sick: 20 days @ 8 hours	(160)
12 Holidays @ 8 hours	(96)
Training hours	(24)
Breaks (0.5 / day * 5 days * 48 weeks)	(120)
Travel (15 hours/week x * 48 weeks)	(720)
<b>Available Billable Hours</b>	<b>960</b>

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TN No. 92-19

Approval Date: \_\_\_\_\_ Effective Date \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

...Table Continued

**Staff Costs**

Annual Salary	\$ 43,500.00	\$36,000 + 1:8 of supervisory \$60,000 salary
Fringe (30%)	\$ 13,050.00	On CSS and Clinical Supervisor salary
Indirect (10%)	\$ 4,350.00	
Rent (\$15/sq.ft x 144 sq.ft x 12 months)	\$ 25,920.00	
Communication (\$100/month x 12 months)	\$ 1,200.00	
Mileage (500 mi/wk x 0.55/mile * 48 wks)	\$ 13,200.00	
Total Cost per Coordinator	\$ 101,220.00	

**Unit Cost per Day of Service**

Total cost / 960 hours \$ 105.44

**Maximum Annual Cost per participant**

General (2 visits/month x 12 months)	24	total visits per participant
	\$ 2,530.50	annual cost per participant
Intensive (5 visits/month x 12 months)	60	total visits per participant
	\$ 6,326.25	annual cost per participant

**Anticipated Average Annual Cost per Participant**

General (1.75 visits/month x 12 months)	21	total visits per participant
	\$ 2,214.19	annual cost per participant
Intensive (4 visits/month x 12 months)	48	total visits per participant
	\$ 5,061.00	annual cost per participant

**Cost per Day Billed to Medicaid** \$ 105.44

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