

MARYLAND REGISTER

# Proposed Action on Regulations

<b>Transmittal Sheet</b>  <b>PROPOSED OR REPROPOSED</b>  <b>Actions on Regulations</b>	<b>Date Filed with AELR Committee</b>	<b>TO BE COMPLETED BY DSD</b>
	05/30/2014	Date Filed with Division of State Documents
		Document Number
		Date of Publication in MD Register

1. Desired date of publication in Maryland Register: 7/11/2014

2. COMAR Codification

**Title Subtitle Chapter Regulation**

10 09 90 01—.14

3. Name of Promulgating Authority

Department of Health and Mental Hygiene

**4. Name of Regulations Coordinator Telephone Number**  
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6. Check applicable items:  
X- New Regulations

- Amendments to Existing Regulations
    - Date when existing text was downloaded from COMAR online: .
  - Repeal of Existing Regulations
  - Recodification
  - Incorporation by Reference of Documents Requiring DSD Approval
  - Reproposal of Substantively Different Text:
    - : Md. R
    - (vol.) (issue) (page nos) (date)
- Under Maryland Register docket no.: --P.

**7. Is there emergency text which is identical to this proposal:**

- Yes  No

**8. Incorporation by Reference**

Check if applicable: Incorporation by Reference (IBR) approval form(s) attached and 18 copies of documents proposed for incorporation submitted to DSD. (Submit 18 paper copies of IBR document to DSD and one copy to AELR.)

**9. Public Body - Open Meeting**

OPTIONAL - If promulgating authority is a public body, check to include a sentence in the Notice of Proposed Action that proposed action was considered at an open meeting held pursuant to State Government Article, §10-506(c), Annotated Code of Maryland.

OPTIONAL - If promulgating authority is a public body, check to include a paragraph that final action will be considered at an open meeting.

**10. Children's Environmental Health and Protection**

Check if the system should send a copy of the proposal to the Children's Environmental Health and Protection Advisory Council.

**11. Certificate of Authorized Officer**

I certify that the attached document is in compliance with the Administrative Procedure Act. I also certify that the attached text has been approved for legality by David Lapp, Assistant Attorney General, (telephone #410-767-5292) on April 8, 2014. A written copy of the approval is on file at this agency.

**Name of Authorized Officer**

Joshua M. Sharfstein, M.D.

**Title**

Secretary

**Telephone No.**

410-767-6500

**Date**

May 30, 2014

**Title 10**

# **DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

## **Subtitle 09 MEDICAL CARE PROGRAMS**

### **10.09.90 Mental Health Case Management: Care Coordination for Children and Youth**

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

#### **Notice of Proposed Action**

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The Secretary of Health and Mental Hygiene proposes to adopt new Regulations .01—.14 under a new chapter COMAR 10.09.90 Mental Health Case Management: Care Coordination for Children and Youth.

#### **Statement of Purpose**

The purpose of this action is to implement a separate targeted case management program for children and youth with serious emotional disturbances. Currently this population is served under a program (COMAR 10.09.45) which serves all age groups. The separation allows the State to implement special provisions related to children and youth.

#### **Comparison to Federal Standards**

There is no corresponding federal standard to this proposed action.

#### **Estimate of Economic Impact**

The proposed action has no economic impact.

#### **Economic Impact on Small Businesses**

The proposed action has minimal or no economic impact on small businesses.

#### **Impact on Individuals with Disabilities**

The proposed action has no impact on individuals with disabilities.

#### **Opportunity for Public Comment**

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499; TTY:800-735-2258, or email to [dhmh.regs@maryland.gov](mailto:dhmh.regs@maryland.gov), or fax to 410-767-6483. Comments will be accepted through August 11, 2014. A public hearing has not been scheduled.

#### **Economic Impact Statement Part C**

A. Fiscal Year in which regulations will become effective: FY 2015

B. Does the budget for the fiscal year in which regulations become effective contain funds to implement the regulations?

C. If 'yes', state whether general, special (exact name), or federal funds will be used:

D. If 'no', identify the source(s) of funds necessary for implementation of these regulations:

E. If these regulations have no economic impact under Part A, indicate reason briefly:

Creation of this new chapter shifts child and youth recipients from the current Targeted Case Management program (COMAR 10.09.45), which will now be limited to adults, into a separate chapter. Cost and enrollment levels are anticipated to remain largely unchanged, as services and payment are comparable.

F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason and attach small business worksheet.

Only a minimal number of small businesses provide Targeted Case Management services.

G. Small Business Worksheet:

Attached Document:

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## **Title 10**

# **DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

### **Subtitle 09 MEDICAL CARE PROGRAMS**

#### ***10.09.90 Mental Health Case Management: Care Coordination for Children and Youth***

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

***.01 Scope.***

*A. This chapter applies to providers organized to deliver mental health case management services for children and youth.*

*B. The purpose of mental health case management care coordination is to assist participants in gaining access to needed medical, mental health, social, educational, and other services.*

***.02 Definitions.***

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

*B. Terms Defined.*

(1) "Care coordination" means services which assist participants in gaining access to a full range of behavioral health services, and, as necessary, any medical, social, financial assistance, counseling, educational, housing, and other support services.

(2) "Care coordination organization (CCO)" means an entity with a minimum of 3 years of experience providing care coordination services that:

(a) Is approved by the Department under this chapter; and

(b) Meets the requirements of COMAR 10.09.89 to provide care coordination to participants in the 1915(i) Community Options for Children, Youth and Families.

(3) "Care coordinator" means an individual employed through the care coordination organization who is responsible for providing care management services to benefit participants and families, including, but not limited to:

(a) Coordination of child and family team meetings; and

(b) Completion of the initial and revised plan of care.

(4) "Child and family team (CFT)" means the group of individuals, including both formal and informal supports and inclusive of the youth and the youth's family, responsible for the creation and implementation of the plan of care.

(5) "Co-occurring disorder" means a diagnosis based on the current Diagnostic and Statistical Manual published by the American Psychiatric Association where the participant is indicated as having both a mental illness and substance use disorder.

(6) "Core service agency" has the meaning stated in COMAR 10.21.17.

(7) "Department" has the meaning stated in COMAR 10.09.36.01 and refers to the Department or its designee.

(8) "Medical Assistance Program" has the meaning stated in COMAR 10.09.36.01.

(9) "Mental Health Case Management: Care Coordination for Children and Youth" has the same meaning as "care coordination" as defined in this regulation.

(10) "Mental health professional" has the meaning stated in COMAR 10.21.17.02.

(11) "Mental health services" means those services described in COMAR 10.09.70.

(12) "Minor" means a child or adolescent younger than 18 years old.

(13) "Natural supports" means any individual who plays a positive, but nonprofessional, role in someone's plan of care.

(14) "Participant" means an individual who meets the qualifications for participation in care coordination that are specified in Regulation .03 of this chapter.

(15) "Plan of care (POC)" means the individualized plan for supports and services prepared according to the requirements outlined in this chapter for a specific participant in care coordination, including a POC developed for 1915(i) participants pursuant to COMAR 10.09.89.

(16) "Program" has the meaning stated in COMAR 10.09.36.01.

(17) "Provider" means the care coordination provider.

(18) "Recipient" has the meaning stated in COMAR 10.09.36.01.

(19) "Residential treatment center (RTC)" has the meaning stated in COMAR 10.07.04.

(20) "Serious emotional disturbance (SED)" has the meaning stated in COMAR 10.21.17.02.

(21) "Young adult" means an individual who is 18 years old or older but not older than 21 years old.

### **.03 Participant Eligibility.**

A. A participant shall be eligible for care coordination services if the recipient:

(1) Is in a federal eligibility category for Maryland Medical Assistance according to COMAR 10.09.24, which governs the determination of eligibility for the Maryland Medical Assistance Program; and

(2) Meets the criteria of either §B(1) or (2) of this regulation.

B. The participant:

(1) Shall:

(a) Meet the diagnostic requirements of being either a:

(i) Minor with a serious emotional disturbance or co-occurring disorder; or

(ii) Young adult with a serious emotional disturbance or co-occurring disorder enrolled in care coordination services continuously under this chapter since reaching age 18; and

(b) Require community treatment and support in order to prevent or address:

(i) Inpatient psychiatric or substance use treatment;

(ii) Treatment in a RTC or residential substance use treatment facility;

(iii) An out-of-home placement;

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

(v) Homelessness or housing instability, or otherwise lacking in permanent, safe housing; or

(vi) Arrest or incarceration due to multiple behavioral health stressors; or

(2) Shall:

(a) Meet the requirements of §A(1)(a); and

(b) Need care coordination 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.

C. A participant that disenrolls after reaching 18 years of age and wishes to re-enroll in care coordination services at a later date shall do so pursuant to COMAR 10.09.45 if more than 120 calendar days has passed since disenrollment.

**.04 Participant Eligibility — Levels of Intensity.**

A. In addition to meeting the eligibility criteria outlined under Regulation .03 of this chapter, participants shall be classified according to the levels of intensity listed in Regulations .05, .06, or .07 of this chapter, based on the severity of the participant's behavioral health or co-occurring disorder, along with assessed strengths and needs.

B. The Department or its designee shall review participant levels of care to confirm these are appropriate to the participants' needs.

C. Participants may not remain at Level III for longer than 6 consecutive months unless approved by the Department or its designee.

**.05 Participant Eligibility – Level I—General Care Coordination.**

The participant as described in Regulation .03A of this chapter shall 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, or food;

C. The participant is transitioning from one level of intensity to another level of intensity of services;

D. The participant needs care coordination services to obtain and maintain community-based treatment and services;

E. The participant:

(1) Is currently enrolled in Level II or Level III Care Coordination services under this chapter; and

(2) Has stabilized to the point that Level I is most appropriate.

**.06 Participant Eligibility –Level II—Moderate Care Coordination.**

The participant as described in Regulation .03A of this chapter shall meet three or more of the following conditions:

A. The participant is not linked to behavioral health services, health insurance, or medical services;

B. The participant lacks basic supports for education, income, food, or transportation;

C. The participant is homeless or at-risk for homelessness;

D. The participant is transitioning from one level of intensity to another level of intensity including transitions out of the following levels of service:

(1) Inpatient psychiatric or substance use services;

(2) RTC; or

(3) 1915(i) services as per COMAR 10.09.89;

E. Due to multiple behavioral health stressors within the past 12 months, the participant has a history of:

(1) Psychiatric hospitalizations; or

(2) Repeated visits or admissions to:

(a) Emergency room psychiatric units;

(b) Crisis beds; or

(c) Inpatient psychiatric units;

F. The participant needs care coordination services to obtain and maintain community-based treatment and services;

G. The participant:

(1) Is currently enrolled in Level III Care Coordination services under this chapter; and

(2) Has stabilized to the point that Level II is most appropriate;

H. The participant:

(1) Is currently enrolled in Level I Care Coordination services under this chapter; and

(2) Has experienced one of the following adverse childhood experiences during the preceding 6 months:

(a) Emotional, physical, or sexual abuse;

(b) Emotional or physical neglect; or

(c) Significant family disruption or stressors.

**.07 Participant Eligibility – Level III – Intensive Care Coordination.**

A. The participant shall meet at least one of the following conditions:

(1) The participant has been enrolled in the 1915(i) program for 6 months or less;

(2) The participant is currently enrolled in Level I or Level II Care Coordination services under this chapter and has experienced one of the following adverse childhood experiences during the preceding 6 months:

(a) Emotional, physical, or sexual abuse;

(b) Serious emotional or physical neglect; or

(c) Significant family disruption or stressors;

(3) The participant meets the following conditions:

(a) The participant has a behavioral health disorder amenable to active clinical treatment, resulting from a face-to-face psychiatric evaluation;

- (b) *There is clinical evidence the minor has a SED and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment;*
  - (c) *A comprehensive psychosocial assessment performed by a licensed mental health professional finds that the minor exhibits a significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, or community;*
  - (d) *The psychosocial assessment supports the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-21, by which the participant receives a score of:*
    - (i) *4 or 5 on the ECSII, or*
    - (ii) *5 or 6 on the CASII;*
  - (e) *Youth with a score of 5 on the CASII also shall meet the conditions outlined in §B of this regulation; and*
  - (f) *Youth with a score of 4 on the ECSII also shall meet the conditions outlined in §C of this regulation.*
- B. Youth with a score of 5 on the CASII shall meet one of the following criteria to be eligible based on their impaired functioning and service intensity level:*
- (1) *Transitioning from a residential treatment center; or*
  - (2) *Living in the community:*
    - (a) *Be at least 13 years old and have:*
      - (i) *3 or more inpatient psychiatric hospitalizations in the past 12 months, or*
      - (ii) *Been in an RTC within the past 90 calendar days; or*
    - (b) *Be 6 through 12 years old and have:*
      - (i) *2 or more inpatient psychiatric hospitalizations in the past 12 months, or*
      - (ii) *Been in an RTC within the past 90 calendar days.*
- C. Youth who are younger than 6 years old who have a score of a 4 on the ECSII either shall:*
- (1) *Be referred directly from an inpatient hospital unit; or*
  - (2) *If living in the community, have two or more psychiatric inpatient hospitalizations in the past 12 months.*

**.08 Conditions for Provider Participation.**

- A. Selection of CCOs.*
- (1) *The local core service agencies shall select child and youth CCOs through a competitive procurement process, at least once every 5 years.*
  - (2) *Regional CCOs may be procured at the mutual agreement of local core service agencies so long as the local core service agencies demonstrate that there is sufficient provider capacity to serve the children and youth in a particular region.*
- B. The CCO shall:*
- (1) *Be approved by the Department as a CCO;*
  - (2) *Commit to coordination with all agencies involved in the participant's POC; and*
  - (3) *Work with the 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.*
- C. 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:*
- (1) *Before employment, submit an application for a child care criminal history record check to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services (DPSCS), in accordance with Family Law Article, §5-561, Annotated Code of Maryland; and*
  - (2) *Request that DPSCS send the report to:*
    - (a) *The director of the agency if the request is from a provider agency concerning staff, volunteers, students, or interns who will work with the participant or family; or*
    - (b) *The Department's designee, if the provider is a self-employed, independent practitioner, or the director of the agency;*
  - (3) *Review the results of the background checks;*
  - (4) *Store background checks in a secure manner consistent with State and federal law; and*
  - (5) *Maintain written documentation in the individual's personnel file that the director and all direct service provider staff including, but not limited to, volunteers, interns, and students, meet the criteria set forth in this regulation.*
- D. Prohibitions Against Utilization of Staff. The provider shall:*
- (1) *Unless waived by the Department in accordance with §E of this regulation, prohibit from working with the participant or the participant's family any staff, volunteers, students, or any individual who is:*
    - (a) *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 a participant;*
    - (b) *Cited on any professional licensing or certification boards or any other registries with a determination of abuse, misappropriation of property, financial exploitation, or neglect; or*
    - (c) *Has an indicated finding of child abuse or neglect.*

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

*(1) For criminal background checks:*

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

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

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

*(2) For abuse and neglect findings:*

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

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

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

*F. The CCO shall provide all three levels of care coordination to ensure continuity of care for participants.*

**.09 Conditions for Provider Participation - Eligibility.**

*A. General Requirements. To be eligible to be approved as a care coordination organization, an entity shall meet all of the:*

*(1) Conditions for participation as set forth in COMAR 10.09.36.03; and*

*(2) Medical Assistance provisions listed in COMAR designated for their provider type.*

*B. Specific Requirements. A CCO:*

*(1) May not place restrictions on the qualified recipient's right to elect to or decline to:*

*(a) Receive care coordination as authorized by the Department; and*

*(b) Choose a care coordinator, as approved by the Department, and other care providers;*

*(2) Shall 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:*

*(a) Minors with a serious emotional disturbance or co-occurring disorder; and*

*(b) Young adults with a serious emotional disturbance or co-occurring disorder;*

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

*(4) Shall 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;*

*(5) Shall convene the first CFT meeting within 30 calendar days of notification of enrollment to begin developing the POC;*

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

*(7) For 1915(i) participants:*

*(a) Shall arrange for the participant and family to meet with peer support partners within 30 calendar 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; and*

*(b) Shall arrange for the participant and family to meet with the intensive in-home service (IIHS) or mobile crisis response service (MCRS) provider, or both, to develop the initial crisis plan within 1 week of enrollment in the 1915(i);*

*(8) Shall assure that:*

*(a) A participant's initial assessment is completed within 10 calendar days after the participant has been authorized by Department and determined eligible for, and has elected to receive, care coordination services; and*

*(b) An initial POC is completed within 15 calendar days after completion of the initial assessment;*

*(9) Shall maintain an electronic health record for each participant which includes all of the following:*

*(a) An initial referral and intake form with identifying information, including, but not limited to, the individual's name and Medicaid identification number;*

*(b) A written agreement for services signed by the participant or the participant's legally authorized representative and by the participant's care coordinator;*

*(c) An assessment as specified in Regulation .07 of this chapter; and*

*(d) A POC as specified in Regulation .07D—E of this chapter;*

*(10) Shall 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;*

*(11) Shall 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, 7 calendar days a week in order to refer:*

*(a) Participants to needed services and supports; and*

*(b) 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;*

(12) 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;

(13) May not provide other services to participants unless the Department approves how conflict of interest standards would be safely addressed.

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

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

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

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

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

(19) 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

(20) Shall commit to coordinating with all agencies involved in the participant's POC.

#### **.10 Mental Health Case Management Care Coordination Provider Staff.**

A. CCOs are required to maintain the following positions:

(1) Care coordinator supervisor who:

(a) 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:

(i) Social work,

(ii) Professional Counseling,

(iii) Psychology,

(iv) Nursing, or

(v) Medicine;

(b) Has a minimum of 1 year of experience in behavioral health working as a supervisor;

(c) Has a minimum of 1 year of experience working with children and youth with mental health or co-occurring disorders;

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

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

(f) Is employed or contracted at a ratio of one supervisor to no more than eight care coordinators;

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

(2) Care coordinator who:

(a) Has at least a:

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

(ii) High school diploma or equivalency and is 21 years or older and 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 meets the training and certification requirements for care coordinators as set forth by the Department;

(b) Is employed by the CCO to provide care coordination services to participants; and

(c) Provides management of the POC and facilitation of the CFT meetings.

#### **.11 Covered Services.**

A. The Department shall reimburse for the care coordination services in this regulation when these services have been documented, pursuant to the requirements in this chapter, as necessary.

B. Care coordination services shall be coordinated with, and may not duplicate activities provided as part of, institutional services and discharge planning activities.

C. Care coordination may include contacts that are directly related to identifying the needs and supports for helping the participant to access services.

D. The CCO shall engage in participant advocacy, including:

(1) Empowering the participant and, if the participant is a minor, the minor's parent or guardian, to secure needed services;

(2) Taking any necessary actions to secure services on the participant's behalf; and

(3) 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.

E. Comprehensive Participant Assessment and Periodic Participant Reassessment.

(1) Providers shall use a child and youth assessment tool approved by the department to perform participant assessments and reassessments.

(2) Initial assessment or reassessment involves the participant's stated needs and review of information concerning the participant's mental health, social, familial, educational, cultural, medical, developmental, legal, vocational, and economic status to assist in the formulation of a POC.

(3) The initial assessment or reassessment of the participant's needs and progress shall be facilitated by the care coordinator and monitored by the CFT, 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.

(4) Coordination and Facilitation of the CFT. The care coordinator shall:

(a) Identify a location for the CFT meetings that is suitable to the participant's needs;

(b) Convene the CFT at least every 6 months, or more frequently, as clinically necessary; and

(c) For 1915(i) participants, convene as per the timeline and functions pursuant to COMAR 10.09.89.

(5) After an initial assessment, each participant shall be reassessed at a minimum of every 6 months.

#### F. Development and Periodic Revision of the POC.

(1) 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.

(2) The CCO shall finalize the POC within 30 calendar days of notification of enrollment and submit it to the Department or its designee.

(3) Development of and updates to the POC shall be youth and family-directed and managed through CFT meetings.

(4) The POC shall meet the requirements of Regulation .12 of this regulation.

(5) The POC development process shall include:

(a) The CFT 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;

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

(c) 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

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

(6) After the POC is developed, the CCO shall update the POC as often as clinically indicated based on the strengths and needs of the participant but not less than:

(a) For Level I participants, every 6 months;

(b) For Level II participants, every 3 months;

(c) For Level III participants, every 45 calendar days; and

(d) For all participants, within seven calendar days following a crisis event.

#### **.12 Covered Services – Plan of Care**

The POC shall contain, at minimum:

A. A description of the participant's strengths and needs;

B. The diagnosis or diagnoses established as evidence of the participant's eligibility for services under this chapter;

C. 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;

D. 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;

E. Designation of the care coordinator with primary responsibility for implementation of the POC;

F. Signatures of the care coordinator and other CFT members, if appropriate;

G. Signatures of the participant and family indicating that the participant and family have:

(1) Participated in the development of the POC; and

(2) Had choice in the selection of services, providers, and interventions, when possible, in the wraparound process of building the POC;

H. An ongoing record of contacts made on the participant's behalf, which includes all of the following:

(1) Date, start and end time, and subject of contact;

(2) Individual contacted;

(3) Electronic or scanned signature of care coordinator making the contact;

(4) Nature, content, and unit or units of service provided;

(5) Place of service;

(6) Whether strategies and tasks specified in the POC have been achieved;

- (7) The timeline for obtaining needed services;
  - (8) The timeline for reevaluation of the plan;
  - (9) The need for and occurrences of coordination with child- and family-serving agencies and providers;
  - (10) The names and contact information for the participant's primary care provider, dentist, and other health care providers;
  - (11) The medications that the participant is currently taking and the dosage and frequency of the medications;
- and
- (12) Monthly summary notes, which reflect progress made towards the identified needs and outcome measures;
- and
- I. For 1915(i) participants, specify for each recommended service the following information as appropriate or as required by the Department:
- (1) Description of the service;
  - (2) Service start date;
  - (3) Estimated duration;
  - (4) Frequency and units of service as measured in 15 minute increments to be delivered;
  - (5) The specific need or goal that the service is related to; and
  - (6) The provider name and contact information.

**.13 Covered Services – Child and Family Team Meetings**

The CCO shall:

- A. Coordinate and facilitate the CFT, with CFT meetings convened at least every 45 calendar days or more frequently as clinically indicated;
- B. Record and keep notes at every CFT meeting that include the CFT 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 CFT members, including those who were not in attendance;
- C. Update the POC to include change in progress, services, or other areas within 5 calendar days of the CFT meeting; and
- D. Ensure that the care coordinator:
  - (1) Facilitates CFT meetings;
  - (2) Facilitates access to the services and supports in the POC; and
  - (3) At the first meeting:
    - (a) Administers the appropriate assessments, as designated by the Department;
    - (b) Works with the participant and family to develop an initial crisis plan that includes response to immediate service needs; and
    - (c) For 1915(i) participants, provides an overview of the wraparound process.

**.14 Covered Services - Referral and Related Activities.**

- A. The care coordinator shall ensure 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, such as mental health services, resource procurement, transportation, or crisis intervention.
- B. The care coordinator shall take the necessary action as defined by the Department when the services identified under Regulation .13 of this chapter have not occurred.
- C. The linkage process shall include:
  - (1) Community and natural support development by contacting, with the participant's consent, members of the participant's support network, including CFT 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;
  - (2) 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;
  - (3) Arranging for the participant's transportation to and from services;
  - (4) 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;
  - (5) Reviewing the POC with the participant and the participant's CFT, 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
  - (6) Provision of health and wellness education, information, and linkages to 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.

**.15 Covered Services - Monitoring and Follow-Up Activities.**

- A. A CCO shall monitor, as per standards set forth by the Department, the activities and contacts that are considered necessary to ensure the POC is implemented and adequately addresses the participant's needs, and include:
  - (1) The participant, or if the participant is a minor, the minor's parent or guardian; and
  - (2) With proper consent:

- (a) Family members and friends, if appropriate;
- (b) Other individuals or agency representatives identified and approved as CFT members by the participant, or if the participant is a minor, the minor's parent or guardian; and
- (c) Other service providers, if any.

**B. The CCO shall:**

(1) Follow up any service referral within seven calendar 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

(2) 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 stated needs and goals for the participant.

C. The CCO shall, in accordance with the decisions and recommendations of the CFT, revise the POC to reflect the participant's changing needs.

**.16 Limitations.**

A. Care coordination services are facilitative in nature.

B. A restriction may not be placed on a qualified recipient's option to receive mental health case management services.

C. Care coordination services do not restrict or otherwise affect:

(1) Eligibility for Title XIX benefits or other available benefits or programs, except as limited by §E of this regulation;

(2) The freedom of a participant or, if the participant is a minor, the minor's parent or guardian, to select from all available services for which the participant is found to be eligible; or

(3) A participant's free choice among qualified providers or, if the participant is a minor, the minor's parent or guardian's free choice among qualified providers.

D. The CCO may not bill the Program for:

(1) The direct delivery of an underlying medical, educational, social, or other service to which a 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 federal Deficit Reduction Act of 2005 (P.L. 109-171);

(4) Activities for which third parties are liable to pay;

(5) Activities delivered as part of institutional discharge planning;

(6) CFT participation, with the exception of when a participant is transferring from one CCO to a different CCO and only with the pre-authorization of the Department; or

(7) A 15-minute unit of service for telephonic contact, unless the provider has delivered at least 8 minutes of service.

E. Reimbursement may not be made for care coordination services if the participant is receiving a comparable care coordination service under another Program authority.

F. A participant's care coordinator may not be the participant's family member or a direct service provider for the participant.

G. Units of services for all levels of care coordination shall be 15 minutes of contact, which may include face-to-face and, with the exception of §G(4) of this regulation, 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, as per the following:

(1) For participants in 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) For participants in 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) For participants in 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; and

(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 6 months thereafter to allow for comprehensive assessment and reassessment of the participant, which shall be performed as a face to face service.

**.17 Preauthorization.**

All covered services under this chapter shall be preauthorized and comply with the requirements of COMAR 10.09.70.07 and COMAR 10.09.89 for services delivered to 1915(i) participants.

**.18 Payment Procedures.**

A. The Program shall reimburse the provider according to the requirements in this chapter and COMAR 10.09.89 for services delivered to 1915(i) participants, and the fees established under COMAR 10.21.25.

B. Request for Payment.

(1) A provider shall submit requests for payment of mental health case management services according to procedures established by the Department.

(2) A provider shall bill the Program for the appropriate fee under COMAR 10.21.25.

(3) The Program may not make direct payment to recipients.

C. Minutes of service and units per participant are to be totaled by day and by service.

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

E. Payment shall be made:

(1) Only to a qualified provider for covered services rendered to a participant, as specified in these regulations; and

(2) According to the requirements of this chapter and COMAR 10.09.89 for 1915(i) participants, and the fees established in COMAR 10.21.25.

F. Service Provision. Units of services for all levels of care coordination shall be 15 minutes of contact, which may include:

(1) 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

(2) Indirect collateral contacts on behalf of the participant with other community providers.

**.19 Recovery and Reimbursement.**

Recovery and reimbursement are as set forth in COMAR 10.09.36.07.

**.20 Cause for Suspension or Removal and Imposition of Sanctions.**

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

**.21 Appeal Procedures.**

Appeal procedures are those set forth in COMAR 10.09.36.09.

**.22 Interpretive Regulation.**

State regulations are interpreted as those set forth in COMAR 10.09.36.10.

**JOSHUA M. SHARFSTEIN, M.D.**

**Secretary of Health and Mental Hygiene**