Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

June 29, 2026

The Honorable Pamela Beidle
Chair
Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Heather Bagnall
Chair
House Health Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

Re: Report Required by Health General Article § 15-1103 - Home and Community-Based Services for Children and Youth 2025 Report (MSAR #14577)

Dear Chairs Beidle and Bagnall:

Pursuant to the requirements of SB 255/HB 322 (Ch. 378/379 of the Acts of 2023) - *Public Health - Home- and Community-Based Services for Children and Youth*, the Maryland Department of Health (MDH) submits this annual report on enrollment in the 1915(i) model and adolescent case management services.

Thank you for your consideration of this information. If you have questions or need more information about the subjects included in this report, please contact Meghan Lynch, Director of Governmental Affairs at meghan.lynch@maryland.gov.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary

cc: Perrie Briskin, Deputy Secretary, Health Care Financing and Medicaid
Rayva Virginkar, Deputy Director, Office of Health Care Financing
Dr. Rachel Talley, Interim Director, Behavioral Health Administration
Meghan Lynch, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

Home and Community-Based Services for Children and Youth

2025 Report

Health-General §15–1103

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Executive Summary

Pursuant to Health-General (HG) § 15-1103, Annotated Code of Maryland, the Maryland Department of Health is submitting the report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on the §1915(i) model and child and adolescent case management services, including:

1. The total number of children and adolescents served by each program;
2. Whether the number represents an increase or a decrease in the number served;
3. Any steps the Department has taken to increase enrollment in the programs; and
4. Information on enrollment and utilization trends in the §1915(i).

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Data was obtained from the Behavioral Health Administrative Service Organization (BHASO). Eligibility for §1915(i) services was originally determined by an income cutoff below 150 percent of the federal poverty level (FPL). On October 1, 2020, this threshold increased to 300 percent FPL, which aligns with the income requirement for both Maryland Medicaid and the Maryland Children's Health Program (MCHP).

Introduction and Overview

The home and community-based services (HCBS) benefit for children and youth with serious emotional disturbances and their families is authorized under a §1915(i) Medicaid State Plan Amendment.

Overview of 1915(i) Model

The §1915(i) State Plan Home and Community-Based Services (HCBS) Option is a federal Medicaid authority established under §1915(i) of the Social Security Act.[1] Created by the Deficit Reduction Act of 2005 and amended by the Patient Protection and Affordable Care Act, Section 1915(i) gives state Medicaid programs the flexibility to cover HCBS through a Medicaid State Plan Amendment (SPA) without the need to seek a federal waiver and without determining that but for the provision of such services individuals would require the level of care provided in a hospital, nursing facility, or intermediate care facility.

In Maryland, the §1915(i) State Plan Option has been designed to provide a comprehensive package of services and support for children, youth, and their families. The program aims to promote stability, reduce dependence on institutional and acute care services, and empower participants to thrive within their communities.

Financial and Clinical Eligibility for 1915(i) Services

Initially, eligibility for §1915(i) services in Maryland was limited to individuals with household incomes up to 150 percent of the federal poverty level (FPL). However, effective October 1, 2020, this eligibility threshold was expanded to 300 percent FPL, aligning it with the coverage provided for children and young adults under the Maryland Medicaid program.[2] This expansion increases access to services for families with significant behavioral health needs while maintaining consistency with broader Medicaid eligibility standards.

Service Delivery Model

Services authorized under §1915(i) are delivered through a wraparound model, which emphasizes individualized, family-centered, and community-based care. The range of services includes:

- Intensive in-home services
- Community-based respite care
- Out-of-home respite care
- Family peer support

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[1] 42 U.S.C. § 1396n(i) (Social Security Act § 1915(i)) – establishing State Plan HCBS authority. (SSA Title XIX reference).https://www.ssa.gov/OP_Home/ssact/title19/1915.htm?utm_source

[2] Maryland State Plan Amendment (SPA) 20-0013, approved by the Centers for Medicare & Medicaid Services (CMS) on September 30, 2020. https://health.maryland.gov/mmcp/Pages/1915%28i%29-Intensive-Behavioral-Health-Services-for-Children%2C-Youth-and-Families.aspx?

- Expressive and experiential behavioral services

This structure aligns with the goals of the Health–General Article, §§ 15–103 and 15–1103, Annotated Code of Maryland, which requires the Maryland Department of Health to administer the State Medicaid program and provide access to behavioral health services for children and adolescents.[3]

Overview Child and Adolescent Case Management Services

Targeted Case Management (TCM) programs are available to assist participants with gaining access to the full range of available mental health services, as well as any needed medical, social, financial, counseling, educational, housing, and other supporting services needed in order to mental wellness and community integration by providing access to needed resources that move them forward in their recovery and help them achieve their individual goals. TCM services are available for children and young adults from birth to age 21. These services are provided at three levels of intensity—Level I, Level II, and Level III—based on the individual needs of the participants and documented medical necessity.[4]

- Level I (General TCM): This is the least intensive level, offering up to 12 units per month (each unit equals 15 minutes, totaling up to 3 hours of treatment). At least two units must include face-to-face contact with the participant.

- Level II (Moderate TCM): This level provides up to 30 units per month (7.5 hours total). A minimum of four units must involve face-to-face contact with the participant.

- Level III (Intensive TCM): This is the most intensive level of service, offering up to 60 units per month (approximately 15 hours total). At least six units must include face-to-face contact with the participant.

This tiered approach ensures that children, youth, and families receive case management support that is tailored to their specific needs, with increased intensity and direct engagement for those who require more frequent assistance.

<u>Targeted Case Management Plus (TCM+)</u>

TCM+is a community-based behavioral health initiative designed to expand access to comprehensive care coordination and family peer support services for up to 100 youth and their families statewide. Services are provided through a contract with the The Maryland Coalition of Families (MCF), which offers family peer support services, linking families with similar lived experience to empower them to understand and access treatment services that meet their unique

[3] Md. Code Ann., Health–General §§ 15–103, 15–1103

[4] See the 2025 Maryland Public Behavioral Health System (PBHS) Provider Manual for detailed descriptions of medical necessity criteria.
https://s18637.pcdn.co/wp-content/uploads/sites/75/carelon-maryland-pbhs-provider-manual.pdf

needs, recovery supports, and other resources. The TCM+ program prioritizes families with private insurance or those ineligible for Medical Assistance. TCM+ was established through Chapter 379, Maryland Laws of 2023.

These services are delivered by local Care Coordination providers with oversight and support from BHA. BHA reviews referrals submitted by the designated point of contact—an organization contracted to manage the referral and invoicing process—determines eligibility, and authorizes services in six-month increments. Families are then connected directly with a provider in their community, where a tailored plan of care is developed to address the specific needs of the youth and family.

FY2024 Enrollment and Utilization of §1915(i) Services and Targeted Case Management (TCM)

A total of 13 children and youth were enrolled statewide in § 1915(i) services. In FY 2024, funding for the §1915(i) program was allocated as follows:

- L0102 – Uninsured §1915(i): $545,850.35
- L0103 – State-Funded §1915(i): $994,233.57

A total of 1,924 children and young adults received TCM services statewide, accounting for approximately 1.5 percent of all Public Behavioral Health System (PBHS) youth and young adult service utilization. Also in FY2024, a total of 165 young adults aged 18-21 accessed TCM.

The distribution of TCM service levels in FY 2024 demonstrated that most children and youth required moderate levels of support rather than minimal or intensive interventions:

- Level II Services (Moderate Intensity): 56 percent (1,073 youth)
- Level I Services (Least Intensive): 36 percent (686 youth)
- Level III Services (Most Intensive): 8 percent (165 youth)

This distribution suggests that the majority of children and youth require moderate levels of support rather than minimal or highly intensive interventions.

<u>TCM Service Use by Age, Race, and Gender</u>

In FY 2024, the statewide TCM service use rate was 2.2 per 1,000 Medicaid-eligible youth and young adults. Utilization patterns reveal disparities across various subgroups:

- By Age: Youth aged 13–17 had the highest usage rate at 4.4 per 1,000 Medicaid-eligible individuals, followed by youth aged 7–12.
- By Race: Non-Hispanic White youth accessed services at nearly twice the rate of Non-Hispanic Black youth, with rates of 4.4 and 2.3 per 1,000, respectively.
- By Gender: Males utilized TCM services more frequently than females, with rates of 2.6 per 1,000 for males compared to 1.8 per 1,000 for females.

These differences highlight inequities in access, referral, or engagement with TCM services.[5] Males participate at higher rates (2.6 per 1,000) compared to females (1.8 per 1,000). This suggests that service needs and referral patterns differ across genders.

1915(i) and TCM Program Improvement Measures

Due to the limited enrollment in and use of both 1915(i) services and TCM services, along with extensive stakeholder feedback, the Department has taken measures to strengthen participation and access. These efforts include:

- Revising eligibility criteria to expand enrollment opportunities (discussed in greater detail in *Next Steps*, below).
- Encouraging local jurisdictions to select multiple care coordination providers to increase participant choice and reduce access barriers.
- Contracting with Health Management Associates (HMA), a national healthcare consulting firm, to facilitate stakeholder listening sessions and identify barriers that youth and families face in accessing services to update the Medicaid State Plan to reflect feedback received.

Trends and Findings in Enrollment and Utilization Trends and Findings

Enrollment in §1915(i) services has steadily declined over the past three years. In FY22, 35 children and youth were enrolled in §1915(i) services. By FY24, enrollment had decreased to 13 children and youth, a 63 percent reduction in participation. This trend highlights ongoing challenges in outreach, eligibility determination, and sustained engagement with the program. In addition, as enrollment declines, providers may experience difficulty with financial sustainability, ultimately leading to discontinuance. Providers can often achieve greater efficiency (also termed “economies of scale”) with increased size because they are able to spread out high fixed costs—like facilities, equipment, and administrative costs—over a larger number of clients.

The overall utilization of TCM services has also declined. In FY19, 2,260 children and youth received TCM services; in FY24, that number dropped to 1,924. This 15 percent decline in participation suggests reduced uptake of services over time, despite the program's availability at various intensity levels. There is also a decline in TCM Utilization among young adults aged 18–21: in FY19, 246 young adults received TCM services which decreased to 165 in FY24. This 33 percent decline underscores the challenges in maintaining service continuity during the transition from adolescence to adulthood.

[5] Hoffmann, J. A., Alegría, M., Alvarez, K., Anosike, A., Shah, P. P., Simon, K. M., & Lee, L. K. (2022). Disparities in Pediatric Mental and Behavioral Health Conditions. *Pediatrics*, *150*(4), e2022058227. https://doi.org/10.1542/peds.2022-058227

In FY2024, the TCM+ program expended $868,240 of its total $1,179,766 grant allocation. This funding supported 775 TCM+ authorizations, assisting up to 72 concurrently . Of the total grant,$1,161,028 was designated for program operations and $18,738 for administrative costs. MCF also serves as a fiduciary for customized goods and services (CGS). CGS are funds that support reasonable and necessary expenses for youth enrolled in TCM+ that align with their therapeutic goals and promote self-determination and community integration. A reasonable cost is one that a prudent person would incur under similar circumstances, while a necessary cost is one that directly addresses a specific need or improves outcomes identified in the youth's Plan of Care (POC). CGS expenditures should be guided by the Child and Family Team, and youth's choices, with support from their family and community, to foster creativity, accountability, and progress toward wellness goals outlined in the POC. Approved expenditures typically fall within the categories of wellness and self-care, educational support, emotional support, recreation, safety, and various therapeutic treatments. Specific examples include tutoring, art supplies, fitness, enrollment in therapeutic programs (e.g., music academy, specialized summer camps). Funding is limited, as outlined in Chapter 379, Maryland Laws of 2023, and approved on a first-come, first-served basis at the discretion of BHA.

Throughout FY24, MCF supported 201 youth in obtaining 494 CGS items to further their therapeutic goals, expending $126,233 of its total $150,000 grant allocation. Funding was allocated across a variety of wellness categories: recreation/fitness (30 percent), self-care/stress management (30 percent), summer camp (16 percent), educational support (13 percent), hobbies (10 percent), and skill-building classes/equipment (1 percent).

Next Steps

BHA and Medicaid amended the 1915(i) and submitted it to the Centers for Medicare and Medicaid Services (CMS) in January 2025 and received approval of the changes in April 2025.[6] A second SPA was approved in September 2025 that modified TCM.[7] These revisions necessitate corresponding changes to the Code of Maryland Regulations (COMAR) 10.09.89 et seq. and 10.09.90 et seq. which implement the 1915(i) and TCM programs, respectively.

The April 2025 SPA expanded the eligibility criteria for 1915(i) services by lowering the minimum score necessary for enrollment for both the Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ECSII); expanding participant eligibility so participants who receive a score of 5 or higher on the CASII do not have to meet additional needs-based criteria; updating the frequency for Plan of Care (POC) reviews and Child and Family Team meetings from every 30 days to every 60 days; removing the

[6] MD-25-0002, Intensive Behavioral Health Services for Children, Youth, and Families § 1915(i) home and community-based services (HCBS) state plan amendment (SPA). https://www.medicaid.gov/medicaid/spa/downloads/MD-25-0002.pdf

[7] MD-25-0008, Targeted Care Management: Care Coordination for Children and Youth. https://www.medicaid.gov/medicaid/spa/downloads/MD-25-0008.pdf

separate reimbursement for telephonic peer support services and clarifying that Family Peer Support Services can be provided in-person and via audio-visual and audio-only telehealth consistent with the *Preserve Telehealth Access Act of 2025* (Chapter 481, 2025 Maryland Laws), and adding coverage of Youth Peer Support Services. Eligibility determinations will transition from local behavioral health authorities to the BHASO to promote equity in access to services.

Informational outreach will continue statewide to promote the changes resulting from the updates to the waiver, with full implementation scheduled to occur upon the finalization of COMAR regulations. Over the past several months, presentations on TCM, TCM+, and 1915(i) have been conducted with multiple state agencies, including the Departments of Social Services and Juvenile Services, residential treatment facilities, and local behavioral health authorities. In addition, outreach and collaboration efforts have included presentations and engagements with community partners such as the Maryland Hospital Association and the Maryland Department of Health's Behavioral Health Advisory Committee. Efforts will also focus on expanding the provider network and pursuing targeted initiatives with local jurisdictions and community stakeholders to enhance awareness and visibility of the services available through the 1915(i) State Plan.

In December 2024, BHA issued a Request for Applications (RFA) to support statewide trainings in evidence-based interventions, capacity building and site implementation support for the following models: Family Centered Treatment (FCT), the Evidence Based Practice (EBP)[8] - Intensive In-Home Services (IIHS) model, and/or In-Home Intervention Program for Children (IHIP-C). This multi-layered RFA sought to both expand provider capacity by providing training and technical assistance required to train additional staff from an existing 1915(i) IIHS provider agency and recruit and educate prospective providers on the opportunity to serve youth receiving IIHS through the 1915(i). A vendor was selected to provide the training and technical assistance in the EBP - IIHS, FCT.

BHA has been working collaboratively with the BHASO, Carelon, to streamline the authorization process for TCM. The goal of this effort is to simplify and expedite the approval process for care coordination providersBHA and Carelon have developed a more comprehensive and structured authorization process, and communicated those changes via provider alters. In addition, a joint training was facilitated by Carelon and BHA staff to walk care coordination organizations through the new process and to address provider questions. To further support implementation, a Frequently Asked Questions document is under development and will be made available to all providers, in conjunction with an open office hours session.

[8] Evidence-based practices are shown to be effective based on rigorous evaluations. See, e.g., the California Evidence-Based Clearinghouse for Child Welfare https://www.cebc4cw.org/ and the Administration for Children and Families Title IV-E Prevention Services Clearinghouse https://preventionservices.acf.hhs.gov/.

Conclusion

BHA has dedicated significant resources to enhancing TCM and 1915(i) services. Efforts to address stakeholder concerns and implement their recommendations remain ongoing. The work to expand the provider network will align with stakeholder suggestions and recommendations, ensuring that a greater number of youth receive the support and services they need. These initiatives aim to expand services to more effectively reach youth and their families and facilitate their earlier engagement in the treatment process.