State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy

M. Targeted Case Management – Individuals under 21 with Serious Emotional Disturbance (SED)

1. **Target Group:** The target group includes individuals under 21 with a Serious Emotional Disturbance (SED) including individuals with co-occurring conditions.

2. **Areas of State in Which Services Will be Provided**

   Services are available state-wide

3. **Comparability of Services**

   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)

4. **Definition of Services**

Targeted Case Management Services (Intensive Care Coordination) is defined as follows:

1. Assessment: The Care Manager, working with the Care Planning Team, may use multiple tools, including a strengths-based standardized assessment instrument, in conjunction with a comprehensive psychosocial assessment and other clinical information to organize and guide the development of an individualized care plan. The Care Planning Team is a source for information needed to form a complete assessment of the child. The Care Planning Team includes, as appropriate, the Care Manager, providers, case managers from state agencies that provide services to the child, family members, and natural supports such as neighbors, friends and clergy. Assessment activities include, without limitation: the Care Manager 1) assisting the family to identify appropriate members of the Care Planning Team; 2) facilitating the Care Planning Team to identify strengths and needs of the child and strengths and needs of family in meeting the child's needs and 3) collecting background information and plans from other agencies. The assessment process will determine the needs of the child for any medical, educational, social or other services. Further assessments will be provided as medically necessary.

2. Development of an individualized care plan: Using the information collected through an assessment, the Care Manager, convenes and facilitates the Care Planning Team, together with the Team develops a person and family-centered, Individual Care Plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Care Manager works directly with the child, the family (or the child's authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the child's needs. .

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3. Referral and Related Activities: Using the individual Care Plan, the Care Manager (1) convenes, coordinates and communicates with the Care Planning Team to implement the Individual Care Plan; (2) works directly with the child and family to implement elements of the Individual Care Plan; (3) prepares, monitors and modifies the Individual Care Plan in concert with the Care Planning Team; (4) coordinates the delivery of available services, including services reimbursable under 42 USC 1396d(a) and educational, social or other services; (5) develops, in concert with the Care Planning Team, a transition plan when the child has achieved the goals of the Individual Care Plan; and (6) collaborates with other service providers on the child and family's behalf.

4. Monitoring and follow-up activities include reviewing the Individual Care Plan every quarter and convening the Care Planning Team at least annually to update the Plan of Care to reflect the changing needs of the child. The Care Manager and the Care Planning Team perform such reviews and include (1) whether services are being provided in accordance with the Individual Care Plan (2) whether the services in the Individual Care Plan are adequate and (3) whether there are changes in the needs or status of the individual and if so, adjusting the Care Plan as necessary.

Services may include contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individuals to access services.

5. Qualifications of Providers:

Providers are agencies known as Community Service Agencies (CSAs) that meet requirements established by the single state Medicaid Agency. To meet such requirements, CSAs must have at least three years' experience providing behavioral health services to youth, from birth to 21 years old, and their families. CSAs are community based child and family service organizations such as community mental health centers, not-for-profit social service agencies and other service providing agencies. CSAs must employ or contract with licensed behavioral health clinicians or non-licensed staff or paraprofessionals supervised by licensed behavioral health clinicians to provide case management services known as Intensive Care Coordination (ICC). Non-licensed staff or paraprofessionals include staff members with a master's degree or a bachelor's degree or with an associates degree and at least five years of experience working with the target population. The case manager, known as the Care Manager, develops and coordinates a child specific care planning team that develops an individualized, child centered, family and strengths-based Plan of Care.

6. Free Choice of Providers

a. Free choice of providers of case management services may be restricted in accordance with the provision of 1915(g)(1) of the Medicaid Act as amended by Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 and 42CFR 431.51.

b. Eligible members will have free choice of providers of other medical care under the plan

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7. Non-Duplication of Payment

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8. Intensive Care Coordination Services To Individuals in Institutions

Nothing in the definition excludes the provision of Intensive Care coordination to individuals who are in hospitals, ICF-MRs, Institutions for Mental Disease (IMDs), Psychiatric Residential Treatment Facilities (PRTFs), and Skilled Nursing Facilities who meet the definition of the target population described above.

a. Such Intensive Care Coordination Services may by provided to individuals transitioning to a community setting. Intensive Care Coordination Services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

b. These activities shall be coordinated with, and not duplicate, institutional discharge planning.

c. The amount, duration, and scope of Intensive Care Management activities will be documented in the Member's Individual Care Plan

d. Transitional Intensive Care Coordination is provided by and reimbursed only to CSAs

e. The Commonwealth will monitor compliance with these provisions through a system that includes periodic audits and claims reviews.

9. Limitations on Qualified Providers

Providers are limited to regionally based, Community Service Agencies that MassHealth determines are most qualified to provide Intensive Care Coordination to members with SED including co-occurring disorders. These limitations will ensure that individuals within the target group receive needed services by establishing a defined group of providers who have and maintain expertise in the special service needs of this population.

10. Additional Assurances

The State assures that:

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

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deny the provision of other services under the plan.

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred.
- Activities for which third parties are liable to pay as described in 42 USC 1396n (4) (A).

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State Plan under Title XIX of the Social Security Act
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Methods and Standards for Establishing Payment Rates – Other Types of Care

XI. Case Management for individuals under age 21 with a serious emotional disturbance – This service is reimbursed using 15-minute unit rates with separate fee schedules based on practitioner qualifications. The rate methodology is based on a model budget that assumes program costs (direct and indirect) and maximum productivity time specific for the provision of each service. The data sources for program costs include cost reports for providers of similar behavioral health services and budget data from other purchasers of similar services. The model budge assumes a maximum productivity time for each service based on an estimated time available for the direct contacts by eligible direct care staff.

The fee-for-service rates were set as of November 1, 2008. These fixed rates are effective for service provided on or after July 1, 2009. All rates are published on www.mass.gov/dhcfp. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.