

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

CASE MANAGEMENT SERVICES

A. Target Group:

Children with a behavioral health disorder under 19 years of age.

B. Areas of state in which services will be provided:

/XX / Entire State

/ / Only in the following geographic areas. Authority of section 1915(g)(l) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services:

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

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

D. Definition of Services:

Case Management services mean the "continuum of assessment, planning, linkage, support and advocacy activities systematically carried out by an individual case manager that are available to assist and enable a recipient to gain access to needed medical, clinical, social, educational or other services."

Separate payment for case management services will not be available when the same case management service is provided as an integral and inseparable part of another Connecticut Medical Assistance Program covered service or included as part of a Medicaid funded service, including but not limited to the following: outpatient clinic services, inpatient services, substance abuse treatment services, psychiatric/psychological evaluation, individual therapy, group therapy, or family therapy.

Case management services will be reimbursable when documentation of compliance with the following requirements is on file with the provider:

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TN No. 94-015

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1. A written care plan of services developed by the case manager at least annually with medical providers, social workers, educators, and the eligible person and/or their representative(s) to address identified needs; and
2. A permanent service record containing the eligible person's name, address and other relevant information including signed monthly service entries indicating the date(s), place of service, duration and type(s) of case management services rendered.

E. Qualification of Providers:

Qualified providers include: a) licensed outpatient psychiatric clinics for children reimbursable under the Medicaid clinic option (not including Federally Qualified Health Centers or general hospital outpatient clinics); b) direct service staff within community-based child rehabilitation programs; and c) psychiatrists, psychologists, and other behavioral health practitioners, operating independently or within a group practice and enrolled in the Connecticut Medical Assistance Program.

F. Freedom of Choice:

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

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Non-Duplication of Payments:

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

H. Access to Services:

The State assures that case management services will not be used to restrict an individual's access to other services under the plan.

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The State assures that individuals 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.

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.

For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community, the State makes the following assurances:

The State assures that the amount, duration, and scope of the case management activities would be documented in an individual's plan of care which includes case management activities prior to and post-discharge, to facilitate a successful transition to the community.

The State assures that case management is only provided by and reimbursed to community case management providers.

I. Case Records:

Providers maintain case records that documents for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management services; the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; whether the individual 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.

J. Non-Duplication of Payments:

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

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A detailed description of the reimbursement methodology identifying the date used to develop the rate is included in Attachment 4.19B.

REQUIREMENTS DESCRIBED IN CMS 2237 IFC

K. Limitations:

Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
- Activities integral to the administration of foster care programs;
- Activities for which an individual may be eligible, that are integral to the administration of another non-medical program, except for the case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

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STATE/TERRITORY: CONNECTICUT

Methods and Standards for Establishing Rates -Other types of Care

20. Targeted Case Management

C. Targeted Case Management for Children with Behavioral Health Disorders

a) licensed outpatient psychiatric clinics for children reimbursable under the Medicaid clinic option (not including Federally Qualified Health Centers or general hospital outpatient clinics): Providers are paid on a unit-of-service basis that does not exceed 15 minutes. Each unit shall be priced no greater than 30% of the Medicare fee for individual psychotherapy, 45-50 minutes, (90806), corresponding to the level of professional that is providing the service.

b) direct service staff within community-based child rehabilitation programs: Providers are paid on a unit-of-service basis that does not exceed 15 minutes. Each unit shall be priced no greater than 30% of the Medicare fee for individual psychotherapy, 45-50 minutes, (90806) and corresponding to the level of professional that is providing the service. In the case of services provided by a paraprofessional, the Medicare reference fee shall be 60% of the Medicare physician fee for individual psychotherapy, 45-50 minutes, (90806). For home-based service models that provide both rehabilitation and targeted case management services, the state may alternatively establish a rate based on the reasonable cost of operating a home-based team and market considerations.

c) psychiatrists, psychologists, and other behavioral health practitioners, operating independently or within a group practice: Providers are paid on a unit-of-service basis that does not exceed 15 minutes. Each unit shall be priced no greater than 30% of the Medicare fee for individual psychotherapy, 45-50 minutes, (90806).

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Methods and Standards for Establishing Rates -Other types of Care

21. Pediatric and family nurse practitioners

Rates for each procedure shall be set at 90% of the department's fees for physician procedure codes.

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