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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

February 18, 2015

Roderick Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Mr. Bremby:

We are pleased to enclose a copy of approved Connecticut State Plan Amendment (SPA) No. 08-009, submitted to my office on June 27, 2008. This SPA transmitted a proposed amendment to Connecticut's approved Title XIX State Plan pertaining to Target Case Management (TCM) for Individuals with Chronic Mental Illness (CMI). These services are operated through the Department of Mental Health and Addiction Services (DMHAS).

This SPA has been approved effective July 1, 2008, as requested by the State.

Changes are reflected in the following sections of your approved State Plan:

- Supplement 1 to Attachment 3.1A(2) page 1-6
- Attachment 4.19B, page 15-15h

If you have any questions regarding this matter you may contact Marie DiMartino (617) 565-9157 or by e-mail at Marie.DiMartino@cms.hss.gov

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Kate McEvoy, Director of Medical Administration - Health Services and Supports

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 08-009

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 07-01-08

5. TYPE OF STATE PLAN MATERIAL (Check One):

_X_ 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:
42 CFR 431, 440 and 441

7. FEDERAL BUDGET IMPACT:
a. FFY 2008 $ no impact
b. FFY 2009 $ no impact

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement I to
Attachment 3.1-A(2); Page 1,2,3,4,5 and 6 (new)
Attachment 4.19-B, Page 15-15h

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19-B, Page 15

10. SUBJECT OF AMENDMENT: The Department intends to amend the provisions of its State Medicaid Plan to targeted case management services for individuals with chronic mental illness in order to comply with the new final rule.

11. GOVERNOR'S REVIEW (Check One):

__ GOVERNOR'S OFFICE REPORTED NO COMMENT
__ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
__ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
_X_ OTHER, AS SPECIFIED: Comments, if any, to follow.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME: Michael P. Starkowski

14. TITLE: Commissioner

15. DATE SUBMITTED: June 27, 2008

16. RETURN TO:
State of Connecticut
Department of Social Services - 11th floor – Medical Policy
25 Sigourney Street
Hartford, CT 06106-5033
Attention: Ginny Mahoney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 27, 2008

18. DATE APPROVED: February 18, 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2008

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health Operations

23. REMARKS:
Pen and Ink change to CMS 179 Box 8 approved by State January 29,2015

FORM HCFA-179 (07-92)

State Plan under Title XIX of the Social Security Act
State/Territory: Connecticut

TARGETED CASE MANAGEMENT SERVICES
Individuals with Chronic Mental Illness (Inclusive of Individuals with Substance Use Disorders and Co-Occurring Mental Illness)

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.] Individuals with serious chronic mental illness as defined by the Department of Mental Health and Addiction Services, inclusive of individuals with substance use disorders and co-occurring mental illness.

__X__ Target group includes individuals transitioning to a community setting (e.g. to-from a nursing facility, general hospital, and emergency department but not individuals transitioning to or from an institution for mental disease). Case-management services will be made available for up to _____180_____ **[insert a number; not to exceed 180]** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
__**X**__ Entire State
____ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
__**X**__ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment at admission and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

  [Specify and justify the frequency of assessments.]
  After an initial comprehensive assessment of needs, reassessments occur at least annually but may be done more frequently based on the individual's needs.

TARGETED CASE MANAGEMENT SERVICES
Individuals with Chronic Mental Illness (Inclusive of Individuals with Substance Use Disorders and Co-Occurring Mental Illness)

Assessment should not be less frequent than annually, and in most instances will be more frequent (e.g. monthly, quarterly), to adequately capture any changes to the medical, social, educational and other needs of the client. This frequency is justified because, in general, the individuals served by this section have conditions that do not change frequently. Accordingly, this frequency is sufficient to have appropriate assessments.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring. A minimum of annual monitoring is conducted, and in most cases monitoring will be more frequent (e.g. monthly, quarterly), in order to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. **[Specify the type of monitoring and justify the frequency of monitoring.]**

  Monitoring may be conducted by staff face-to-face or by telephone contact with the individual, by chart review, by case conference, or by collateral contact with family members, service providers, or other entities or individuals.

TARGETED CASE MANAGEMENT SERVICES
Individuals with Chronic Mental Illness (Inclusive of Individuals with Substance Use Disorders and Co-Occurring Mental Illness)

This frequency is justified because, in general, the individuals served by this section have conditions that do not change frequently. Accordingly, the minimum requirement of annual monitoring of the care plan and implementation is sufficient because, as described above, monitoring is done more frequently whenever necessary.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[**Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]**

Provider entities eligible to render targeted case management services are limited to entities who meet the following qualifications and are approved by the Department of Mental Health and Addiction Services (DMHAS) as having the competencies necessary to provide the service. These entities are:

- DMHAS public psychiatric hospital outpatient departments
- DMHAS public outpatient mental health clinics
- Private provider entities specializing in rendering services to individuals with serious chronic mental illness, including, but not limited to, private outpatient mental health clinics and private psychiatric hospital outpatient departments

For the private provider entities listed above, one of the following qualifications are required of individuals employed by or under contract with the qualified private provider entity:

- a physician as defined in section 5 of Attachments 3.1-A and 3.1-B of the State Plan;
- a licensed psychologist, advanced practice registered nurse / nurse practitioner, physician assistant, licensed clinical social worker, licensed marital and family therapist, licensed professional counselor, or licensed alcohol and drug counselor, each as defined in section 6 of Attachments 3.1-A and 3.1-B of the State Plan; a registered nurse licensed by the Department of Public Health, a licensed practical nurse licensed by the Department of Public Health; or a certified alcohol and drug counselor who is certified by the Department of Public Health;

TARGETED CASE MANAGEMENT SERVICES
Individuals with Chronic Mental Illness (Inclusive of Individuals with Substance Use Disorders and Co-Occurring Mental Illness)

- a license-eligible individual whose education, training, skills and experience satisfy the criteria for any of the practitioner categories described immediately above but who has not yet passed the applicable license or certification exam;
- an individual with a minimum of an Associate's Degree in a behavioral health related field or with two (2) years of college training in a behavioral health or rehabilitation therapy field;
- an individual with one (1) or more years of experience working with individuals with mental illness involving participation in an interdisciplinary team process and the development, review and implementation of an individual's plan of services (completion of a mental health trainee certificate program issued by a college or university may be substituted for six (6) months of the General Experience); or
- an individual with Recovery Support Specialist Certification issued by DMHAS or its authorized representative along with six (6) months of experience as a Recovery Support Specialist Trainee.

For the qualified DMHAS public provider entities listed above, the individuals who provide TCM within those DMHAS public entities must:

- Be employed by DMHAS as an Advanced Nurse Practitioner, Associate Professional Counselor, Behavioral Health Program Manager, Behavioral Health Unit Supervisor, Certified Addiction Counselor, Certified Occupational Therapy Assistant, Children Services Worker, Clinical Nurse Coordinator (Psychiatric), Clinical Social Worker, Clinical Social Worker Associate, Clinical Social Worker Licensure Candidate, Community Clinician, Developmental Specialist 1, Developmental Specialist 2, DMHAS Behavioral Health Clinical Manager, Head Nurse, Housing Program Coordinator, Lead Children Services Worker, Lead Nurse Clinician, Licensed Practical Nurse, Marital & Family Therapist, Mental Health Assistant 1, Mental Health Assistant 2, Mental Health Associate, Mental Health Trainee, Nurse, Nurse Clinical Specialist, Nurse Clinician, Occupational Therapist, Occupational Therapist Supervisor, Professional Counselor, Psychiatric Social Worker Assistant, Psychiatric Social Worker Associate, Psychiatric Social Worker Supervisor, Psychologist (Clinical), Recovery Support Specialist, Recovery Support Specialist Trainee, Registered Nurse (Per Diem), Rehabilitation Counselor 2, Rehabilitation Therapist 1 (Therapeutic Recreation), Rehabilitation Therapist 2 (Therapeutic Recreation), Rehabilitation Therapy Assistant 1, Rehabilitation Therapy Assistant 2, Rehabilitation Therapy Supervisor 1, Rehabilitation Therapy Supervisor 2, Supervising Addiction Counselor, Supervising Clinician, Supervising Psychologist 1 (Clinical), Supervising Psychologist 2 (Clinical), Vocational Rehabilitation Counselor (Client/Patient), or Vocational Rehabilitation Counselor Coordinator (Client/Patient); and
- meet one of the qualifications listed above for individuals providing TCM within private provider entities.

TARGETED CASE MANAGEMENT SERVICES
Individuals with Chronic Mental Illness (Inclusive of Individuals with Substance Use Disorders and Co-Occurring Mental Illness)

Freedom of choice (42 CFR 441.18(a)(1)):
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 individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
_**X**___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.
[**Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

See Qualifications of providers listed above (in the section above that references 42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b). No additional limitations.

These limitations specifically enable providers to ensure that individuals within the target groups receive needed services because those providers have training, experience, and other expertise in those services and related areas. Those qualifications are specifically tailored to ensure expertise in working with individuals who have chronic mental illness (including substance abuse disorder and co-occurring mental illness).

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services 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 (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

TARGETED CASE MANAGEMENT SERVICES
Individuals with Chronic Mental Illness (Inclusive of Individuals with Substance Use Disorders and Co-Occurring Mental Illness)

Payment for case management or targeted 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**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.] N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

Methods and Standards for Establishing Rates -Other types of Care

19. Targeted Case Management

A. Targeted Case Management for Persons with Chronic Mental Illness (TCM-CMI)

TCM-CMI services claimed under Medicaid must be substantiated by documentation in the eligible client's permanent service record. A payment for case management services may not duplicate Medicaid payments made for other covered services. The TCM-CMI services are eligible for reimbursement when one or more services are rendered in the billing period, as defined below, and the recipient or their representative approves of such services. The TCM-CMI services rate is a statewide rate based on TCM-CMI reimbursable costs detailed below. The Department of Mental Health and Addiction Services (DMHAS) will be reimbursed at cost for TCM-CMI provided by DMHAS employees and private providers under contract with DMHAS.

The billing period for TCM-CMI services for dates of service July 1, 2008 through November 30, 2010 is a month, and for dates of service December 1, 2010 going forward is a week.

1. TCM-CMI Service Provider Costs

TCM-CMI services are provided by DMHAS employees and private providers under contract with DMHAS. TCM-CMI cost is calculated utilizing the CMS approved cost report and CMS approved RMTS.

a. Random Moment Time Studies (RMTS)

CMS approved random moment time studies are conducted with moments selected on a quarterly basis, but the Time Study is conducted continually. RMTS percentage efforts are calculated each quarter and the SFY quarter results are used for the allocation of direct costs. The Time Study participants include all staff reasonably expected to perform TCM-CMI Services during the time study period.

b. Cost Reports

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

DMHAS annually will complete and certify a Cost Report for costs related to TCM-CMI services provided by DMHAS employees for the period from July 1 through June 30. Private providers under contract with DMHAS will annually submit to DMHAS an Annual Financial Report for the period from July 1, through June 30 and DMHAS certifies the private provider costs. Cost reports are due to the Department of Social Services no later than 10 months following the close of the state fiscal year during which the costs included in the Cost Report were incurred. The annual cost report shall include the certification of funds in accordance with the DMHAS-DSS MOU. Submitted cost reports are subject to desk review by the single state agency or its designee. Desk review will be completed in the 8 months following the receipt of the cost reports.

c. Private Provider Expenditures are calculated in accordance with the following:

i. The total contract amount from DMHAS is compared to the total budget amount of the provider and a percentage is calculated.

ii. Direct service costs of providing TCM services include salary, wage, and fringe benefits that can be directly charged to TCM services. Direct costs shall not include room and board charges.

iii. Other direct costs including mileage reimbursement, translation and interpretation services, leasing of office equipment, training, and necessary office supplies and direct service overhead cost which are directly attributable to support the delivery of TCM services. Mileage reimbursement will be supported with mileage logs documenting actual mileage specific to TCM services, individual receiving services and their Medicaid status at the time of the services.

iv. Total private provider costs are the sum of item ii and item iii.

v. Private provider service costs attributable to DMHAS is calculated by applying the DMHAS contract funding percentage identified in step i to item iv.

vi. Private provider reimbursable TCM-CMI cost is calculated by applying results of the RMTS to item v.

vii. The Medicaid allowable costs for TCM-CMI services are calculated by applying the Medicaid penetration rate to the TCM-CMI reimbursable costs (item vi).

The Medicaid penetration rate is calculated by dividing the state fiscal year monthly average of the number of Medicaid enrolled private provider TCM-CMI clients as of the 5th day of each month during the cost period by the average total number of all private provider TCM-CMI clients as of the same day.

d. Private providers not reimbursed in accordance with the methodology described in section 1.c above are paid in accordance with the applicable rate set forth in the fee schedule for TCM-CMI services. The fee schedule for TCM-CMI services can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download."

e. Payment at Cost for Public Providers are calculated in accordance with the following:

i. Direct service costs of providing TCM services include salary, wage and fringe benefits that can be directly charged to TCM services. Direct costs shall not include room and board charges.

ii. Other direct costs including mileage reimbursement, translation and interpretation services, leasing of office equipment, training, and necessary office supplies which are directly attributable to support the delivery of TCM services. Mileage reimbursement will be supported with mileage logs documenting actual mileage specific to TCM services, individual receiving services and their Medicaid status at the time of the services.

iii. Adjusted direct costs are the sum of item i. and item ii.

iv. TCM-CMI cost is calculated by applying results of the RMTS to item iii.

v. Indirect cost calculated by applying the HHS approved indirect cost rate to item iv.

vi. Total direct cost is the sum of items iv and v.

vii. The Medicaid allowable costs for TCM-CMI services are calculated by applying the Medicaid penetration rate to the TCM-CMI reimbursable costs (item vi).

The Medicaid penetration rate is calculated by dividing the state fiscal year monthly average of the number of Medicaid enrolled DMHAS TCM-CMI clients as of the 5th day of each month during the cost period by the average total number of all DMHAS TCM-CMI clients as of the same day.

2. Interim Rates

Interim rates for TCM-CMI services shall be updated annually. Interim rates are based on the most recent finalized replacement rates for TCM-CMI services provided to Medicaid clients by the Department of Mental Health and Addiction Services and private providers under contract with the Department of Mental Health and Addiction Services based upon the cost settlement, as determined in section 5 below, rounded up to the nearest $10. Interim rates are provisional in nature, pending the completion of cost reconciliation and cost settlement for that period.

3. Monthly Rate.

The monthly rate for TCM-CMI services for dates of services July 1, 2008 through November 30, 2010 is calculated by dividing the total allowable TCM costs (item 1c vi and 1e vii) by the total number of recorded TCM contacts for the same period. No more than one unit will be billed for each Medicaid eligible client in a month for the period of July 1, 2008 through November 30, 2010.

4. Weekly Rate.

The weekly rate for TCM services for dates of services December 1, 2010 through June 30, 2011 is calculated and reimbursed in accordance with methodology in SPA 10-024, approved on August 21, 2011, incorporated by reference herein and attached hereto. The weekly rate for TCM services for dates of services July 1, 2011 going forward is calculated by dividing the total allowable TCM costs (item 1c vi and 1e vii) by the total number of recorded TCM contacts for the same period. No more than one unit will be billed for each Medicaid eligible client in a week for the period December 1, 2010 going forward.

5. Settlement

DMHAS claims paid at the interim rate for TCM-CMI services delivered by DMHAS and private providers during the reporting period, as documented in the MMIS, will be compared to the total Medicaid allowable costs for TCM-CMI services based on the CMS approved Cost Report identified in section 1.b. The Department of Mental Health and Addiction Services interim rate claims for TCM-CMI services will be adjusted in aggregate. This results in cost reconciliation. Reconciliation will occur within 24 months of the end of the reporting period contained in the submitted cost report.

If it has been determined that an overpayment has been made, the Department of Social Services will return the federal share of the overpayment. If the actual, certified Medicaid allowable costs of TCM-CMI services exceed the interim Medicaid rates, the Department of Social Services will submit claims to CMS for the underpayment. Cost settlement will occur within the timelines set forth in 42 CFR 433 Subpart F. Connecticut will not modify the CMS-approved scope of costs, time study methodology or the annual cost report methodology without CMS approval.

6. Audit

All supporting accounting records, statistical data and all other records related to the provision of TCM-CMI services delivered by the Department of Mental Health and Addiction Services' and private providers may be subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted for each fiscal year by the Department of Mental Health and Addiction Services and private providers, the Department of Social Services' payment rate for the said period shall be subject to adjustment.

ATTACHMENT 4.19-B
Page 15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

Methods and Standards for Establishing Rates – Other Types of Care

20. Targeted Case Management

A. Targeted Case Management for Persons with Chronic Mental Illness (TCM-CMI)

1. TCM-CMI services claimed under Medicaid must be substantiated by documentation in the eligible client's permanent service record. A payment for case management services by DSS may not duplicate payments made under the Connecticut Medical Assistance Program for other services which are covered under the program.

2. Payments for TCM-CMI services are made when one or more case management services are rendered in a week and the recipient or their representative approves of such services.

3. Payments for TCM-CMI Services.

   The cost based weekly interim rate for TCM-CMI services provided between December 1, 2010 through June 30, 2011 is based on the prior year costs. The interim rate will be replaced using CMS-approved cost reports and CMS-approved time studies for the period; related payment adjustments will be made accordingly.

   a. For governmental providers, cost reports shall be submitted by December 31st after the rate period (December 1, 2010 through June 30, 2011). Cost reports will include detailed cost data including direct costs, operating expenses related to direct services, indirect costs, and general and administrative costs in support of TCM services which are not included in the indirect cost rate.

   b. For private providers, annual cost reports shall be submitted to the Department of Mental Health and Addiction Services by December 31st after the close of the previous contract year. Costs reports will include detailed cost data including direct costs, other expenses related to direct services. The annual cost report must reconcile with the

audited financial statements submitted to the Department of Mental Health and Addiction Services in the State Single Audit.

c. For governmental providers, direct costs include salary, wage, fringe benefit and operating expenses for TCM-CMI services as reported on the cost report. The TCM-CMI direct cost is derived by applying the percent of time governmental service providers spend on TCM-CMI activities as determined by a CMS approved time study methodology to the TCM-CMI direct cost and operating expenses.

d. Administrative and general cost applicable to the TCM-CMI cost is calculated by applying the percent of time governmental service providers spend on TCM-CMI activities as determined by a CMS approved time study methodology to the General and administrative costs as defined in item a.

e. For private providers, direct service costs include TCM-CMI costs incurred and reported in the cost report. The TCM costs, direct and related other costs, that are paid by other federal or state programs will be removed from the cost pool resulting in the private providers adjusted direct cost. The Department of Mental Health and Addiction Services cost related to administration and monitoring of TCM grants to the private providers is added to the adjusted direct costs resulting in the private providers TCM-CMI service costs. The private provider TCM-CMI service costs are then multiplied by percent of time private providers spend on TCM-CMI activities as determined by a CMS approved time study.

f. Indirect costs are calculated using the indirect cost rate set by the Department of Health and Human Services for the Department of Mental Health and Addiction Services. Indirect costs are equal to direct costs (item c.) multiplied by the indirect cost rate as defined in this section.

g. For governmental providers, total TCM-CMI service cost is the sum of the TCM-CMI service costs for governmental providers (item c) plus the total indirect costs (item f) plus A&G costs as defined in item a.

h. The total identified TCM-CMI Medicaid program allowable service cost is the sum of governmental providers TCM-CMI Medicaid allowable cost plus private providers TCM-CMI Medicaid allowable costs.

For governmental providers the TCM-CMI Medicaid allowable costs are calculated by applying the Medicaid penetration rate to the TCM-CMI costs as identified in item g. The Medicaid penetration rate for governmental providers is the average number of Medicaid enrolled DMHAS TCM-CMI clients as of the 5th day of each month during the cost period divided by the average number of DMHAS TCM-CMI clients as of the same day.

For private providers the TCM-CMI Medicaid allowable costs are identified by applying the Medicaid penetration rate to the TCM-CMI costs (item e.). The Medicaid penetration rate for private providers is the average number of Medicaid enrolled private provider TCM-CMI clients as of the 5th day of each month during the cost period divided by the average number of private providers TCM-CMI clients as of the same day.

The Medicaid penetration rate will be calculated separately for governmental service providers and for private service providers.

i. A TCM-CMI "Unit" is defined as a week. A Medicaid TCM-CMI service "unit" occurs when one or more case management services are rendered during the week to a Medicaid eligible client. The total TCM-CMI Medicaid units rendered during the rate period equals the sum of Medicaid TCM-CMI service weeks for governmental providers plus Medicaid TCM-CMI service weeks for private providers.

j. The weekly TCM-CMI rate is calculated by dividing the TCM-CMI Medicaid allowable costs (item h.) by the total number of Medicaid TCM-CMI units provided during the rate period (item i).

l. A TCM-CMI billing will be triggered when a TCM-CMI service unit occurs during a week. No more than one unit will be billed for each Medicaid eligible client in a week.

4. Cost Reconciliation
The State will fund the December 1, 2010 through June 30, 2011 TCM-CMI services using IGT. The TCM-CMI rate will be replaced using actual costs reported on the CMS-approved cost reports and CMS-approved time studies. The replacement rate will be finalized within 12 months after the end of the rate period. If it has been determined that an overpayment has been made, the Department of Social Services shall return the federal share of the overpayment. If the replacement rate shall exceed the interim rate, the Department of Social Services shall submit claims to CMS for the underpayment.

5. Audit
All supporting financial documentation, permanent service records, statistical data and all other records related to the provision of TCM-CMI services shall be subject to audit. If an audit discloses discrepancies in the accuracy and/or allowance of actual direct or indirect costs or statistical data as submitted by the Department of Mental Health and Addiction Services, the Department's Medicaid reimbursement rate for the said period shall be subject to adjustment.