

## **Table of Contents**

**State/Territory Name: CT**

**State Plan Amendment (SPA) #: 10-024**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

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



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

August 24, 2011

Roderick L. Bremby, Commissioner  
Department of Social Services  
25 Sigourney Street  
Hartford, Connecticut 06106

Dear Mr. Bremby:

We are pleased to enclose a copy of approved Connecticut State Plan Amendment (SPA) No. 10-024, submitted to my office on November 30, 2010. This SPA transmitted a proposed revision to Connecticut's approved Title XIX State Plan in order to modify Attachments 4.19-B of the State Plan pertaining to Targeted Case Management services provided by the Department of Mental Health and Addiction Services (DMHAS) for persons with Chronic Mental Illness.

Under SPA 10-024 the State will sunset the TCM reimbursement methodology effective June 30, 2011, which will also end the problematic funding arrangement. In our letter to the State on June 6, 2011, we outlined the agreement that the State's use of its Gross Appropriation Methodology would end on June 30, 2011 through the submission of a SPA. The State intends to submit a new SPA to begin funding through an approvable mechanism effective July 1, 2011. This SPA has been approved effective December 1, 2010, as requested by the state.

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

- Attachment 4.19-B, page 15
- Attachment 4.19-B, page 15a
- Attachment 4.19-B, page 15b
- Attachment 4.19-B, page 15c
- Attachment 4.19-B, page 16

If you have any questions regarding this matter you may contact Marie Montemagno at (617) 565-1227 or by e-mail at [Marie.Montemagno@cms.hhs.gov](mailto:Marie.Montemagno@cms.hhs.gov).

Sincerely,

Richard R. McGreal  
Associate Regional Administrator

**TRANSMITTAL AND NOTICE OF APPROVAL  
OF STATE PLAN MATERIAL  
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:  
10-024

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:  
12-01-2010

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

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 2010    no fiscal impact  
b. FFY 2011    no fiscal impact

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Page 15,  
Attachment 4.19-B Page 15a and 15b  
Attachment 4.19-B Page 16

9. PAGE NUMBER OF THE SUPERSEDED PLAN  
SECTION OR ATTACHMENT (If applicable)

Attachment 4.19-B, Page 15  
(New)  
(New)

10. SUBJECT OF AMENDMENT:

The Department of Social Services is proposing to revise its Medicaid State Plan effective December 1, 2010. The Department intends to modify Attachments 4.19-B of the Connecticut Medicaid State Plan concerning targeted case management services provided by the Department of Mental Health and Addiction Services.

The projected fiscal impact is \$0 in SFY10 and \$0 in SFY11.

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

OTHER, AS SPECIFIED:

12.

13. TYPED NAME: Michael P. Starkowski

14. TITLE: Commissioner

15. DATE SUBMITTED:  
November 30, 2010

16. RETURN TO:

State of Connecticut  
Department of Social Services - 11<sup>th</sup> floor - Medical Policy  
25 Sigourney Street  
Hartford, CT 06106-5033  
Attention: Ginny Mahoney

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: November 30, 2010

18. DATE APPROVED: August 24, 2011

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
December 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL 

21. TYPED NAME: Richard R. McGreal

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

23. REMARKS: CMS and the Connecticut Department of Social Services mutually agreed to amend Box 8 to add page 15c to Attachment 4.19-B. In addition, the State agrees to sunset the targeted case management reimbursement methodology effective June 30, 2011 and agrees to submit a new SPA to address their Gross Appropriation Methodology.

# OFFICIAL

ATTACHMENT 4.19-B  
Page 15

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

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### 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 31<sup>st</sup> 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 31<sup>st</sup> 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

TN No. 10-024 Approval Date 08-24-2011 Effective Date 12-01-2010  
Supersedes  
TN No. 96-007

# OFFICIAL

ATTACHMENT 4.19-B  
Page 15a

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

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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.

# OFFICIAL

ATTACHMENT 4.19-B  
Page 15b

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

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- 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.

# OFFICIAL

ATTACHMENT 4.19-B  
Page 15c

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CONNECTICUT

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- 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.

TN No. 10-024 Approval Date 08-24-2011 Effective Date 12-01-2010  
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TN No. 96-007

# OFFICIAL

Attachment 4.19B  
Page 16

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

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- (21) Pediatric and family nurse practitioners - Rates for each procedure shall be set at 90% of physician fees as noted on Attachment 4.19B, page 1(a)ii, item (5) above.

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