

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

**STATE/TERRITORY: CONNECTICUT**

**CASE MANAGEMENT SERVICES**

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**A. Target Group:**

Recipients with chronic mental illness as defined in Subsection (g), Section 1915 of the Social Security Act who are part of the target population as defined by the State of Connecticut Department of Mental Health and Addiction Services (DMHAS) and amended from time to time.

**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."

Definition of service:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

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Comprehensive assessment 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 individual.

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- 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:

- To help an eligible individual obtain needed services including activities that help link an individual with
- medical, social, educational providers or
- other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

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- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

For plans that provide case management services to assist individuals who reside in medical institutions to transition to the community: Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities.

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 DMHAS or its performing providers:

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 and type(s) of case management services rendered.

**E. Qualification of Providers:**

DMHAS and its subcontractors shall be the sole entities enrolled to provide services through the use of Connecticut's provider agreement which assures federal and state

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regulatory compliance. Qualified case managers shall include individuals employed by DMHAS who are State of Connecticut employees or employees of an agency receiving a grant from DMHAS to provide case management services and are recognized by DMHAS as qualified to provide such services.

**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.

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 individuals will receive comprehensive, case management services on a one-to-one basis, through one case manager.

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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.

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

**K. Limitations:**

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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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Methods and Standards for Establishing Rates -Other types of Care

20. Targeted Case Management

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

The Medicaid rate for TCM-CMI services is based upon the cost of Department of Mental Health and Addiction Services (DMHAS) personnel engaged in case management and other DMHAS and state costs allocable to service provision in accordance with applicable Federal reimbursement regulations. TCM-CMI costs for case management service obtained through DMHAS contracts with private non-profit agencies. Allowable TCM-DD costs are divided by the number of case management service days.

Payment for case management services by DSS is made only when one or more case management activities are rendered in a calendar month; the receipt of said services occurs at the option of the eligible person or their representative; 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.

Case management services are eligible for payment by DSS only when documentation of compliance is on file.

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