APHSA Side by Side of TCM DRA Provisions and TCM Interim Final Rule

Areas where TCM Interim Final Rule Goes Beyond DRA Conference Report		
Issue	**DRA Conference Report Agreement Sec. 6052**	• **CMS Description of TCM Interim Final Rule**
Restriction to One Case Manager	• **Not Specifically Mentioned in DRA**	• When an individual could be served under more than one TCM plan amendment because he falls within the scope of more than one target group, a decision must be made concerning the appropriate target group so that the individual will have one case manager responsible for his services and duplicate payment for the same purpose will not be made. An exception is made for medical assistance for covered Medicaid services, including case management services, furnished to a child with a disability because such services are included in an IEP or IFSP. • CMS requires case management services to be provided on a one-to-one basis to eligible individuals by one case manager. They are including this requirement to implement the provisions of section 1915(g)(2)(A)(ii) that sets forth a unified case planning process for case management to respond to the needs of eligible individuals based on a comprehensive assessment.
Case Managers Restriction from Authorization	• **Not Specifically Mentioned in DRA**	• Providers of case management services are prohibited from exercising the State Medicaid agency's authority to authorize or deny the provision of other services under the plan. • Costs related to these activities, such as prior authorization or determination of medical necessity, which are necessary for the proper and efficient administration of the Medicaid State plan, must be claimed as a direct administrative expense and not included in the development of a case management rate.
Funding Methodology	• Defines the Medicaid TCM benefit, and codifies the ability of states to use an approved cost allocation plan (as outlined under OMB Circular A-87, or other related or subsequent guidance) for determining the amount that can be billed as Medicaid TCM services when case management is also reimbursable by another federally-funded program.	• While a State has some flexibility to establish the methodology and rates it will use to reimburse providers of case management or targeted case management services, a State cannot employ a methodology or rate that result in payment for a bundle of services. CMS believes that the most efficient and economical unit of service is a unit of 15 minutes or less. • When the cost of any part of case management or TCM are reimbursable under another federally funded program, a State is directed by section 1915(g)(4)(B) of the Act to allocate costs which are reimbursable under the other Federal program in accordance with OMB Circular No. A-87 under an approved cost allocation.
Integral Component	• **Not Specifically Mentioned in DRA**	• The case management benefit does not include, and FFP is not available for, activities that are an integral component of another Medicaid service. To include those activities as a separate benefit will result in duplicate coverage and payment.

Benefit Restrictions	• **Not Specifically Mentioned in DRA**	• Case management benefit does not include services that involve the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred. • Case managers can assist individuals in gaining access to needed services, regardless of the funding source of the service to which the individual is referred. • If a case manager provides a direct service, such as counseling, during the course of a case management visit, the direct service cannot be reimbursed as part of the case management services. This service may be covered under another Medicaid service category, such as rehabilitation services. • The performance of diagnostic tests also is a direct service and do not constitute an assessment activity. • Referral and related activities do not include the provision of transportation or escort services, nor do they include the provision of day care services so that an eligible individual with children can access needed services.
CM for Transitioning Individuals	• **Not Specifically Mentioned in DRA**	• Services CMS define as case management services for transitioning individuals from medical institutions to the community will be included as a separately covered case management services • Individuals (except individuals ages 22 to 64 who reside in an institution for mental disease (IMD) or individuals who are inmates of public institutions) may be considered to be transitioning to the community during the last 60 consecutive days (or a shorter period as specified by the State) of a covered long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered short term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. • FFP would not be payable until the date that an individual leaves the institution, is enrolled with the community case management provider, and receiving medically necessary services in a community setting.
Exclusions for Incarceration	• **Not Specifically Mentioned in DRA**	• "Except as otherwise provided in paragraph (16), such term [medical assistance] does not include (A) any such payments with respect to case management or services for any individual who is an inmate of a public institution. An individual is considered to be living in secure custody if serving time for a criminal offense in, or confined involuntarily to, State or Federal

		prisons, local jails, detention facilities, or other penal facilities. • Case management services could be reimbursed on behalf of Medicaid eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, and are not used in the administration of other non-medical programs.
Exclusions for IMD	• **Not Specifically Mentioned in DRA**	• FFP does not extend to other services furnished to individuals under age 21 residing in these settings. However, FFP is available for community case management services to transition an individual receiving inpatient psychological services for individuals under age 21, after discharge from a medical institution to the community. FFP would not be payable until the date that an individual leaves the institution, is enrolled with the community case management provider, and receiving medically necessary services in a community setting.
Child Welfare/Child Protective Services Exclusion	• **Not Specifically Mentioned in DRA**	• Child protective services include development and oversight of a service plan for the child and family with the goal of moving the child toward permanency. Because these services have their own goals' protecting vulnerable children and moving them toward a safe and stable living situation, CMS believes child protective services are the direct services of State child welfare programs and are not Medicaid case management. • Thus, Medicaid case management services must not be used to fund the services of State child welfare/child protective services workers. Further, Medicaid may not pay for case management services furnished by contractors to the State child welfare/child protective services agency, even if they would otherwise be qualified Medicaid providers, because they are furnishing direct services of the programs of that agency. • However, children receiving child welfare/child protective services may still qualify to receive Medicaid TCM services when these services are provided according to the Medicaid State plan program by a qualified Medicaid provider who is not furnishing direct services of other programs.

Parole and Probation	• **Not Specifically Mentioned in DRA**	• Because probation and parole functions are necessary and integral components of the administration of another system, we believe that parole and probation functions are the direct services of corrections program and are not Medicaid case management. • Thus CMS is prohibiting the use of parole or probation officers (or other employees or contractors of the justice system or court) as case management providers under Medicaid. • Individuals who are on parole or probation may still qualify to receive Medicaid case management or TCM services for which they otherwise qualify.
Public Guardianship	• **Not Specifically Mentioned in DRA**	• Individuals that have been determined to need guardians, because they are found incapable of handling their own affairs, may qualify for Medicaid case management when they are also part of a group to whom this service is provided . • Therefore, case managers may assist guardians and others, in enabling an individual to gain access to needed services, but they may not be used to replace or fund the function of this fundamentally non-Medicaid activity.
Special Education	• **Not Specifically Mentioned in DRA**	• While some of the services identified on a child's IEP may be covered under Medicaid, the development, review, and implementation of the IEP is part of a process that is required by Part B of the IDEA. This process should not be confused with Medicaid case management or TCM services, which also may be needed by the child. • The IFSP process requires a service coordinator from the outset, some of whose activities may be Medicaid-funded case management or TCM services. • An IEP or IFSP may identify the need for case management to coordinate access to a broad range of medical service providers from several disciplines, and also may identify needs for case management to gain access to non-medical services. Such case management services may be covered under Medicaid when furnished to a Medicaid-eligible child by a Medicaid qualified provider who assists in gaining access to and coordinating all needed services. • To facilitate coordinated care, case management is a covered Medicaid service only when a single case manager comprehensively addresses all of the individual's service needs. • While a case manager may be operating in a school or early intervention program in assisting IDEA-eligible children.

		Medicaid may pay for those case management services where IDEA and Medicaid overlap, but not for administrative activities that are required by IDEA but not needed to assist individuals in gaining access to needed services. • FFP is not available for any case management activities not included in an IEP or IFSP but performed solely based on obligations under section 504 of the RA to ensure equal access to the educational program or activity • Nothing in this rule would prohibit or restrict payment for medical assistance for covered Medicaid services furnished to a child with a disability because such services are included in the child's IEP or IFSP. • Medicaid funds must not be used to replace or otherwise supplant funds used for activities related to the administration of the IDEA for infants and young children such as Child Find.
Foster Care	• `(iii) Such term does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including, with respect to the direct delivery of foster care services, services such as (but not limited to) the following: • `(I) Research gathering and completion of documentation required by the foster care program. • `(II) Assessing adoption placements. • `(III) Recruiting or interviewing potential foster care parents. • `(IV) Serving legal papers. • `(V) Home investigations. • `(VI) Providing transportation. • `(VII) Administering foster care subsidies. • `(VIII) Making placement arrangements.	• CMS is also including in §441.18(c) (3) the specific statutory examples of excluded services because they are direct delivery of care with respect to foster care as: 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; or making placement arrangements. • Since the statue cites these administrative activities as examples, rather than as an all-inclusive list, at §441.18(c) (3), we are interpreting the exclusion of administrative activities to extend to all administrative activities integral to the administration of the foster care program. • Other foster care activities subject to this payment exclusion include case management; referral to services; overseeing foster care placements; the training, supervision, and compensation of foster care parents; and attendance at court appearances related to foster care. • Since the activities of foster care programs are separate and apart from the Medicaid program, Medicaid case management services must not be used to fund the services of foster care workers. • FFP for the medical services to which a Medicaid-eligible child who resides in foster care was referred would be available under the Medicaid program. • Furthermore, case management activities included under therapeutic foster care programs will be subject to this payment

		exclusion since these activities are inherent to the foster care program • FFP for medical services to a Medicaid eligible child with medical care needs who resides in therapeutic foster care would still be available, provided all Medicaid requirements were met.
Other Exclusions	• **Not Specifically Mentioned in DRA**	• CMS will exclude from the case management benefit the administrative activities of any other non-medical program. • Exclusion of Medicaid funding for case management activities that are used in the administration of other non-medical programs does not, in any way compromise Medicaid recipients' eligibility for medically necessary services under the plan, including medically necessary case management and TCM services that are not used to administer other programs.
Administrative Exclusion	• **Not Specifically Mentioned in DRA**	• In addition, activities that meet the definition for case management services under the approved State plan cannot be claimed as administrative activities. Certain activities may be properly claimed as administrative costs when the activities are directly related to the proper and efficient administration of the Medicaid State plan. • Ex. Medicaid eligibility determinations and re-determinations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; prior authorization for Medicaid services; utilization review and Medicaid outreach. CMS may make determinations that other activities qualify. • Not eligible to be claimed are activities that are an integral part or extension of a direct medical service.
Case Management Approach	• **Not Specifically Mentioned in DRA**	• Case managers can use a person-centered approach. The process focuses on the person rather than the system: directly involves the person in the plan development.
Qualifications for Providers	• **Not Specifically Mentioned in DRA**	• States must establish qualifications for providers of case management services in the State plan. A State has flexibility to establish qualifications that are reasonably related to the demands of the Medicaid case management services.

Areas where TCM Interim Final Rule Codified Current Law and is consistent with DRA Conference Report		
Issue	**DRA Conference Report Agreement Sec. 6052**	• **TCM Interim Final Rule**
TCM Benefit definition	• Specifically, the proposal would clarify that the TCM benefit includes the following: • (1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources; • (2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs; • (3) referral and related activities to help an individual obtain needed services; and • (4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs.	• **1. Assessment and periodic reassessment** of an eligible individual to determine service needs. • Assessment activities include: Taking client history; Identifying the needs of the individual and completing related documentation; 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. • **2. Development and periodic revision of a specific and comprehensive care plan** based on the information collected through an assessment or reassessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. An individual may decline to receive services in the care plan. • **3. Referral and related activities**(such as scheduling appointments) to help an individual obtain needed services. Transportation, escort and child care services are not included in referral and related activities. • **4. Monitoring and follow-up activities** include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring should occur no less frequency than annually.
Case Management Definition	• The term `case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.	• CMS will define case management services generally as services that assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. The intent of case management is to assist the individual in gaining access to needed services, consistent with the requirements of the law and these regulations. "Other services" may include services such as housing and transportation.
TCM Definition	• The term `targeted case management services' are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas.	• CMS defines TCM services as case management services furnished to particular defined target groups or in any defined locations without regard to requirements related to statewide provision of services or comparability.
Definition of an Eligible Individual	•	• An "eligible individual" is a person who is eligible for Medicaid and eligible for case management services (including targeted case management services) as defined in the Medicaid State plan, at the time the services are furnished.

Permissible contact with non-Medicaid eligible individuals	• In cases where a TCM provider contacts individuals who are not Medicaid eligible or who are not part of the TCM target population, the activity could be billed as TCM services if the purpose of the contact is directly related to the management of the *eligible* individual's care.	• Contacts with family members that are for the purpose of helping the Medicaid-eligible individual access services can be covered by Medicaid.
Non-permissible contact with non-eligibles	• If the contact is related to the identification and management of the non-eligible or non-targeted individual's needs and care, the activity may not be billed as TCM services.	• Case management as medical assistance under the State Plan cannot be used to assist an individual who has not yet been determined eligible for Medicaid, to apply for or obtain this eligibility.
Third party coverage	• Specifies that federal Medicaid funding would only be available for TCM 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.	• The State's plan must provide that case management services will not duplicate payments made to public agencies or private entities under the State plan and other program authorities.
Limiting providers for certain groups	•	• States are given the option of limiting providers of case management services available to furnish services for targeted groups that consist solely of individuals with DD or Chronic MI. This implements the statutory provisions at section 1915(g) (1) of the act.
Free Choice of Providers	•	• Individuals must have the free choice of any qualified provider. The State must ensure that a conflict of interest does not exist that will result in the case manager making self-referrals. • A state also cannot condition receipt of case management services on the receipt of other services since this also serves as a restriction on the individual's access to case management services. • Providers of case management services are prohibited from serving as gatekeepers under Medicaid. • However, States may use a section 1915(b) waiver or primary care case management services under section 1905(a) (25) for this purpose.
Managed Care Exemption	•	• Individuals participating in a managed care plan receive case management services as an integral part of the managed care services. This case management is for the purpose of managing the medical services provided by or through the plan and does not extend to helping an individual gain access to social, educational, and other services the individual may need. Thus, an individual receiving services through a managed care plan may also receive case management or TCM services when the individual is eligible.
Effective Date	• Effective January 1, 2006.	• Effective March 3, 2008