Enclosure A
Technical Assistance Tool
Optional State Plan Case Management
[CMS-2237-IFC]

BASIC PROVISIONS OF SECTION 6052 OF THE DRA

1) **What is contained in section 6052 of the Deficit Reduction Act of 2005 (DRA), Reforms of Case Management and Targeted Case Management and the related rule, CMS-2237-IFC?**

   Answer:

   Section 6052 refined the definition of Medicaid case management and targeted case management (TCM). Part of that definition consisted of examples of Medicaid case management activities, as well as excluded activities. The interim final rule with comment period (IFC) implements and interprets the provisions of section 6052. The rule contains further guidance pertaining to the coverage of Medicaid case management and targeted case management services.

2) **What are Medicaid case management and targeted case management services?**

   Answer:

   Case management includes services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Targeted case management are case management services provided only to specific classes of individuals, or to individuals who reside in specified areas of the State (or both). Case management does not include the underlying medical, social, educational and other services themselves, integral components of covered Medicaid services, nor does it include activities integral to foster care programs or other non-medical programs (with a few exceptions discussed below).

3) **What are the components of case management?**

   Answer:

   Case management services are comprehensive and must include all of the following: assessment of an eligible individual (42 CFR 440.169(d)(1)); development of a specific care plan (42 CFR 440.169(d)(2)); referral to services (42 CFR 440.169(d)(3)); and monitoring activities (42 CFR 440.169(d)(4)).

4) **What services and activities do the statute and regulation exclude from Medicaid reimbursement as case management services?**

   Answer:

   Medicaid reimbursement is not available as case management services for services or activities that do not comport with the definition of Medicaid case management. Nor is Medicaid reimbursement available as case management when any of the following conditions exist: 1) Case management activities are an integral component of another covered Medicaid service; 2) 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, but not limited to, services under parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services, and foster care programs; 3) The activities are integral to the administration of

foster care programs; and, 4) The activities, for which an individual may be eligible, are integral to the administration of another non-medical program, such as a guardianship, child welfare/child protective services, parole, probation, or special education program except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Act.

There might be some confusion because there are administrative activities that have been previously referred to as "case management" such as prior authorization or referral to Medicaid services but that do not meet the definition of case management. States can continue to claim the costs of such activities as administrative costs. Services that meet the definition of case management services must be covered under the approved State plan cannot be claimed as administrative activities. (See Administrative Activities section below for further clarification).

5) **What are some examples of activities that are not within the scope of Medicaid case management and would be excluded from Medicaid reimbursement?**

Answer:

The DRA provided examples of activities that are not included within the scope of Medicaid case management that are related to the administration of foster care programs, such as home investigations and providing transportation. We have interpreted this statutory language to represent the types of activities which are excluded from the definition of case management, rather than as isolated exclusions. The listed activities in the statute represent instances where there could be cost shifting from the foster care program to Medicaid; we have interpreted the language to apply to similar activities where there could be cost shifting from other programs to Medicaid. Thus the exclusions define types of non-Medicaid costs for which Medicaid cannot pay, rather than the sole instance of inappropriate cost-shifting. The rule applies these same payment principles to all Medicaid case management services including special education programs (under the Individuals with Disabilities Education Act), parole and probation functions, legal services, child welfare/child protective services and guardianship.

6) **What is the effective date of this rule? What steps are States expected to take to come into compliance with the new rule? Are SPAs or waiver program revisions necessary? If so by when?**

Answer:

Section 6052 of the Deficit Reduction Act of 2005 was effective on January 1, 2006. This legislation provides a specific definition of Medicaid case-management and details the types of activities that should not be funded by the Medicaid program. This section of statute also authorized the Secretary to promulgate an Interim Final Rule with Comment Period (IFC), which appeared in the Federal Register on December 4, 2007. The provisions of the IFC became effective 90 days thereafter, March 3, 2008.

We recognize that there are certain provisions of the IFC that may pose significant implementation challenges to States; specifically the single case manager provision and the applicability of the IFC provisions to the 1915 (c) home and community-based waiver program. As such, additional time has been granted to implement these two provisions. The IFC states that States have up to one year after their next legislative sessions to adopt

practices to comply with the single case manager provision. Question 29 of this guidance document addresses the compliance timeframes for the 1915 (c) program. Also, please be advised that as CMS drafts the final rule, we intend to propose modifications of the 15-minute increment provision of the IFC. Specifically, we intend to recommend that the final regulation permit an extended timeframe for implementation as well as additional flexibility with respect to units of service.

We recommend that States submit State Plan Amendments (SPAs) no later than June 30, 2008 to revise the reimbursement, coverage, and eligibility provisions of their approved Medicaid State plans that will be affected by the regulation. CMS is developing additional guidance regarding SPA submittals. We further recommend States to engage their appropriate Regional Office staff in discussions regarding their current compliance status and potential SPA submittals.

7) **Does the rule address who may provide case management services? Is there an exception to this rule?**

Answer:

Individuals must be free to choose their case management provider from among those that have qualified to participate in Medicaid and are willing to provide the services. However, while the freedom of choice requirement is beneficial to the Medicaid population as a whole, Congress recognized that this requirement might not adequately protect the interests of persons with a developmental disability or chronic mental illness. When a target group consists solely of individuals with developmental disabilities or chronic mental illness, States may limit provider participation to specific persons or entities by setting forth qualifying criteria that assure the ability of the case managers to connect individuals with needed services.

8) **Can a participant choose his or her individual case manager?**

Answer:

Yes. Individuals may choose freely among those case managers or entities that the State has found qualified to provide case management services. Absent a waiver to the contrary, such individuals also maintain their right to choose qualified providers of all other Medicaid services they receive.

9) **Are States subject to public notice requirements prior to implementing the provisions in this regulation?**

Answer:

Yes. We expect that most States will need to do public notice because of changes to the reimbursement methodologies necessary to come into compliance with the provisions of this regulation. Such proposed changes qualify as a significant change in methods or standards of setting payment rates that meet the requirement for public notice as described in section 42 CFR 447.205 of the Medicaid regulation.

10) **What assistance will CMS provide to States (particularly those moving from a system where there were limited providers) as they open their systems to all willing and qualified providers?**

Answer:

The CMS will provide ongoing technical assistance to States as they explore options available for the delivery of case management for home and community based waiver populations. Specifically, CMS can assist States as they develop provider qualifications (for those States previously offering case management as an administrative component) and make necessary system modifications to accommodate the change. For those States interested in continuing to limit the providers of services for case management, CMS is available to provide technical assistance on section 1915(b)(4) or other authorities. States continue to have the ability to set provider qualifications for any Medicaid provider including providers of case management as long as they are reasonably related to the ability to effectively serve the targeted population. Furthermore, because the rule applies in total to Home and Community-Based Services (HCBS) waivers, States may, as described above, limit provider participation to specific persons or entities by setting forth qualifying criteria that assure the ability of the case managers to connect individuals with needed services when the target populations are individuals with developmental disabilities or individuals with chronic mental illness.

11) Are there options available to States who wish to restrict the providers of case management (for populations other than persons with developmental disabilities and those with mental illness)?

Answer:

To the extent the Secretary finds it cost effective and efficient and not inconsistent with the purposes of title XIX, section 1902(a)(23) may be waived through 1915(b)(4) or other authorities to restrict the provider from (or through) whom an individual can obtain services.

12) What is the applicability of TCM Reg for Disease Management?

Answer:

There is no impact on disease management. Disease management is typically a direct service offered either through a managed care organization, a primary care case manager, or individual practitioners. It is a coordinated package of care comprised of preventive, diagnostic and/or therapeutic services to a specific group of individuals who have, or are at risk for, a chronic illness or condition and does not include the same components to meet the definition of case management. In contrast, case management or targeted case management providers may not provide direct services such as disease education, medical monitoring, or instruction in health self-management. Please refer to the State Medicaid Directors letter #04-002 for disease management guidance.

13) Is it possible for individuals to have more than one case manager and what determines who is the single case manager for Medicaid?

Answer:

Medicaid case management facilitates access to needed services through a comprehensive assessment, care planning, referral to services and monitoring. Individuals may receive non-comprehensive services including some components of case management through other resources, but Federal Financial Participation (FFP) is available for case management services that meet the definition of Medicaid case management and targeted case management services as defined in the rule only from a single case manager rather than from multiple providers or under multiple TCM target groups. Before submitting claims for Medicaid payment, a qualified case manager will need to ascertain from the State Medicaid

agency whether the individual is already obtaining Medicaid case management services from another provider. If so, additional Medicaid payment will be available only when the prior case management assessment and plan is outdated, the Medicaid-eligible individual has agreed to receive case management services, and has chosen the provider.

This provision is based on the principles of: one accountable provider who has ultimate responsibility for the delivery of all components of the case management service; and the existence of a system that ensures there is no duplication of service and payment for case-management services. We recognize that in order to accomplish the goal of coordinating and developing a comprehensive, integrated plan of care, the single case manager may need to consult with other providers with specialized expertise. Further, it is important to recognize the distinct differences between case management and other reimbursable Medicaid services. Case management as a service should function to promote access to the direct delivery of other services.

CMS also recognizes that for supervisory purposes or during absences it may be practical for States to have structures in place that ensure continuity of care. In these instances, we would not view this as a violation of the one case manager provision. CMS is interested in working with States to ensure that the principles related to accountability and non-duplication of services are met in the delivery of quality case management services.

14) **May a State provide TCM that is specific to only limited services (e.g., IEP services) as long as the individual is not enrolled in any other case management program?**
Answer:
No. The definition of case management specifies that these services assist Medicaid eligible individuals to access needed services including medical, social, educational, and other services. This list is broad and does not provide for limiting the needed services.

Please note that per section 1903(a) of the Social Security Act (the Act), nothing in the 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 Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Likewise, payment for those services that are included in the IEP or IFSP would not be available when those services are not covered Medicaid services.

15) **Existing TCM services may include groups identified as Children with IEP's, Juvenile Justice Youth, or Foster Care Children. Can States continue to target these groups given that FFP is no longer available for case management services integral to the administration of another non-medical program including education, juvenile justice, and foster care?**
Answer:
Section 1915(g)(2) states that targeted case management services may be offered to individuals in any defined location of the State or to individuals within target groups specified in the State Plan. This provision provides States the flexibility to target case management services to specific classes of individuals who represent special populations in need of case management services. The new rule retains this provision. However, the new rule includes several provisions (others may apply, as well) that may have an impact on TCM

services targeted to these particular groups. Please refer to the rule for an explanation of the following points:

- FFP is not available for activities integral to the administration of foster care programs. Examples of these activities are included in the rule and under 45 CFR 1340.14, 45 CFR 1355.33- 45 CFR 1357.16, and 45 CFR 1356.60. For example, since case management is an administrative activity under title IV-E foster care, it is likely that Medicaid TCM services targeted to a group comprised of children eligible for title IV-E would be considered integral to that program and thus FFP would not be available under Medicaid. Similarly, the title XX block grant includes services/administrative activities for "preventing and remedying neglect, abuse, or exploitation of children…or preserving rehabilitating or reuniting families."
- Case management may not be furnished by an employee or contractor of a juvenile justice, child welfare, or foster care program. For example, 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.
- The State may not restrict participants' freedom of choice of Medicaid providers for Medicaid case management/targeted case management.
- The definition of the target group would include the need for services.
- Case management services included in an individual's IEP or IFSP are treated differently. Under section 1903(c), covered Medicaid services are furnished to a child with a disability even when such services are included in the child's Individualized Education Program IEP or Individualized IFSP. In this case Medicaid is the first payor for covered services in an IEP or IFSP. (See rule for further guidance.)

16) **Do you think the limitation on gate keeping applies only to State plan services? Or to all Medicaid services? Does it prevent a case manager (transition coordinator) from authorizing transition services?**

Answer:

Yes. We included section 441.18(a)(6) to prohibit providers of case management services from exercising the State Medicaid agency's authority to authorize or deny the provision of other services under the plan. Although a State Medicaid agency may place great weight on the informed recommendation of a case manager, it must not rely solely on case management recommendations in making decisions about the medical necessity of other Medicaid services that the individual may receive. Medical necessity and the decision to authorize the provision of a service must remain with the State Medicaid agency as required by section 431.10(e). 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 by the Medicaid agency and may not be included in the development of a case management rate.

17) **One State contracts with a non-state agency to do an assessment, level of care and a care plan as an "authorized agent of the state." Notices to consumers are sent on department letterhead that states that the organization is functioning as the State's authorized agent. Will this arrangement still be allowed?**

Answer**:**

Yes. States may continue to enter into agreements with other entities to provide certain functions for the proper and efficient administration of the State plan or to provide services. However, the focus is whether the targeted case management services meet the definition described in the rule, are claimed as a service, and individuals maintain choice of qualified provider, with the exceptions of target groups including individuals with chronic mental illness or developmental disabilities.

18) **When an individual qualifies for more than one targeted case management group or waiver program, how will States determine the individual's case manager?**

Answer:

Consistent with a person-centered approach, when an individual could qualify for case management services under more than one benefit, the individual or the legal representative of the individual, would have a choice of the case management service and provider. In addition, the individual or legal representative would have a choice not to receive the service. With the case manager, the individual or legal representative can participate throughout all components of case management and direct who may participate in the care plan development process.

19) **Can States establish provider qualifications that would result in limiting individuals' choice of providers of targeted case management services to only a county agency or Tribal provider?**

Answer:

No. Other providers may qualify to provide these services because States must ensure freedom of choice of providers and establish provider qualifications that are reasonably related to the provision of the service. To restrict an individual's choice of willing and

qualified providers, a waiver of section 1902(a)(23) would be needed. The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of title XIX, may waive this requirement. States may wish to contact CMS for guidance on the statutory authorities that would waive the "freedom of choice of provider" provision.

20) If a State is providing TCM as a service under section 1115 authority as part of the benefit package, do these regulations apply?

Answer:

Yes. States providing TCM as a State plan service under section 1115 demonstrations would provide TCM as defined in the rule.

21) Do these regulations also apply to case management services offered under EPSDT?

Answer:

Yes. The EPSDT statutory language at section 1905(r)(5) mandates the provision of any medically necessary Medicaid coverable 1905(a) services to any eligible child. However, services provided under EPSDT must be provided in accordance with statutory and regulatory guidance governing the provision of those services under Medicaid. The description of case management in section 5310. D in Chapter 5 of the State Medicaid Manual does not supersede the definition of case management as defined in the rule. Therefore, the policies set forth in the rule apply to the definition of case management services as provided under EPSDT.

22) Do these regulations also apply to case management services offered under the State Children's Health Insurance Program (SCHIP)?

Answer:

Yes. To the extent an SCHIP program is offered as a Medicaid expansion program, the rule applies because these programs follow Medicaid rules.

23) If the State has a Money Follows the Person (MFP) grant, where the State is enrolling nursing facility transitionees into an established waiver, can the State utilize the full 6 months of pre-transition coordination and support as specified in that established waiver?

Answer:

Yes. The State can use the 6 months of case management before the waiver is renewed and has to come into compliance provided the waiver includes the services. MFP does not change current waiver policy.

IMPLEMENTATION

24) Will there be a preprint for states to use in amending their SPA? (Is there going to be an SMD letter with the preprint as an attachment?)

Answer:

A suggested State plan outline for sections 3.1A and B that would meet the requirements of the rule may be located in Enclosure B. CMS is available to provide technical assistance on an individual basis to States seeking to amend SPAs or other programs. A SMD letter will not be issued since CMS-2237-IFC provides needed guidance.

IMPACT ON 1915(c) WAIVER PROGRAMS

25) Do these regulations also apply to case management provided as a service under 1915(c) Home and Community Based Services waiver programs?

Answer:

Yes. CMS has determined that the policies set forth in CMS-2237-IFC will apply to the definition of case management services as provided under section 1915(c) Home and Community Based Services waiver programs.

26) Does the provision of the regulation that requires choice of providers except for those populations (persons with chronical mental ill/developmental disabilities) apply to case management provided as a service under 1915(c) Home and Community Based Services waiver programs?

Answer:

Yes. The choice of provider requirements will apply to case management services provided under section 1915(c) Home and Community Based Services waiver programs. However, as noted above, the State may choose to limit providers when the population served includes individuals with developmental disabilities or individuals with chronic mental illness.

27) What if a State has designed a service in a 1915(c) waiver under the "other" category that incorporates elements of case management but also includes other elements of scope?

Answer:

The CMS will analyze the service to determine its alignment with the case management definition in CMS-2237-IFC. To the extent that the service aligns with the regulatory definition of case management, the regulations will apply.

28) If a State has historically offered case management for their 1915(c) waiver program as an administrative activity to restrict the providers of the function (i.e., to State government staff or Area Agencies on Aging), will they be able to continue in this fashion under this new rule?

Answer:

States must identify the activities claimed as administration and compare the activities to the definition of case management services. If these activities are a case management service, then the service must be claimed as medical assistance. If the activities are for the proper and efficient administration of the State Plan, then reimbursement would be claimed as administration. See Question #29 for a discussion of administration.

Individuals' free choice of qualified Medicaid provider is an important beneficiary protection included in Statute that is also consistent with a person-centered approach to providing services. When a State chooses to include case management services as medical assistance, per section 1902(a)(23) of the Act and section 9508 of COBRA, individuals eligible to receive case management or targeted case management services must be free to choose a case management provider from among those qualified to participate in Medicaid and willing to provide the services. (Section 1915(g)(1) of the Act includes an exception that allows States to limit the providers of case management services available for individuals with

developmental disabilities or chronic mental illness.) To restrict an individual's choice of willing and qualified providers, a waiver of section 1902(a)(23) would be needed. The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of title XIX, may waive this requirement. States may wish to contact CMS for guidance on the statutory authorities that would waive the "freedom of choice of provider" provision.

When activities are administrative, the State Medicaid Agency may enter into interagency agreements with other governmental entities to perform certain administrative functions for the proper and efficient administration of the State plan such as identifying and enrolling potential eligibles into Medicaid. The interagency agreement would describe and define the activities each party to the agreement offers, under what circumstances, and the relationship between the State Medicaid agency and the participating agency.

29) What steps are States expected to take to regarding 1915(c) waiver programs to come into compliance with the new rule?

Answer:

For renewal waivers with an effective date between March 3, 2008, and March 3, 2010, States must be compliant with the regulation no later than March 3, 2010. All other waivers must be compliant by the time of their next waiver renewal. (Examples: A waiver with a renewal date of July 1, 2008, will be given until March 3, 2010, to be compliant; a waiver with a renewal of July 1, 2009, must be compliant by March 3, 2010; a waiver with a renewal date of January 1, 2011, must be compliant at the time of renewal). Note: All States will be advised of these timelines to ensure compliance by the appointed timeframes. Because the renewal cycle for waivers is no greater than 5 years, all waivers will be in compliance no later than March 3, 2013.

The CMS will not approve new waivers submitted after March 3, 2008 that are not compliant with CMS-2237-IFC.

No amendments to waivers that would render the State out of compliance with CMS-2237-IFC submitted after March 3, 2008 will be approved.

30) Can States continue to claim for assessment and development of an interim care plan under administration?

Answer:

Yes. Activities for the proper and efficient administration of the State Plan may continue to be claimed under administration as long as they are not duplicative of costs claimed through the rate paid for direct medical services.

31) Case managers in some States may perform some tasks (preadmission assessment, and prior authorization (of waiver services) that look like they can be covered as an administrative expense and others that fall under case management. Are these costs claimable under administration?

Answer:

Costs related to activities such as prior authorization or determination of medical necessity, which are necessary for the proper and efficient administration of the Medicaid State plan,

may be claimable as a direct administrative expense by the Medicaid agency and must not be included in the development of a case management rate. These activities are administrative and do not comport with the definition of Medicaid case management.

32) How will States ensure health and welfare of waiver participants under this rule ?

Answer:

Any activities that the State pursues to ensure health and welfare that are consistent with the definition of case management and its required components would be allowable under case management. For all activities that fall outside the definition of case management, e.g. quality assurance and improvement activities, States may claim them as administrative activities. For individuals who refuse case management services, the State may carry out the functions necessary to assure health and welfare through the use of State staff or contractors. This may be claimed administratively. An example of such an arrangement may include a State Quality Assurance staff person who, in addition to broad-based system-related quality assurance activities, will undertake person-specific monitoring in instances when the individual refuses case management. This activity may include monitoring the plan of care, or providing service referrals, along with other actions necessary to meet the statutory health and welfare assurance.

33) Will States that currently cover case management as an administrative activity rather than a waiver service, continue to do so until the date of which the 1915(c) waiver is expected to be in compliance?

Answer:

Yes. Please see the timeframes in #29.

34) How does the 15 minute unit relate to the waivers?

Answer:

Because the entirety of the rule applies to 1915(c) waivers, the State must utilize reimbursement methodologies that are consistent with the rule. CMS has prepared technical guidance with regard to rate determination that may be useful to States as they construct their rates. Also, please be advised that as CMS drafts the final rule, we intend to propose modifications of the 15-minute increment provision of the IFC.

ADMINISTRATIVE CLAIMING

35) Are administrative activities that include elements of, but are less comprehensive than, case management or targeted case management services able to continue to be billed under administration?

Answer:

Administrative activities for the proper and efficient administration of the State plan can continue to be claimed under administration. For example, an administrative activity may include assisting an individual, who has not yet been determined eligible for Medicaid, to apply for or obtain this eligibility. The following activities are allowable:

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;

- Prior authorization for Medicaid services;
- Utilization review; and
- Outreach activities to inform or persuade beneficiaries or potential beneficiaries to enter into care through the Medicaid system.

36) What happens if a State submits a cost allocation plan but won't be in compliance with the regulation by the time the cost allocation needs to be approved?

Answer:

Federal regulations at 42 CFR 433.34 require that the State Medicaid agency have an approved public assistance Cost Allocation Plan (CAP) on file with the Department of Health and Human Services that meets regulatory requirements specified at Subpart E of 45 CFR Part 95. The State Medicaid agency is at risk for any claims submitted prior to approval of an amendment to the public assistance CAP.

However, approval of a CAP amendment, or lack thereof, does not dictate when a State must be in compliance with the CM/TCM regulation. CMS works directly with the Division of Cost Allocation in the CAP amendment review and approval process. Therefore, if CMS has reached agreement with a State regarding a plan for compliance with the CM/TCM regulation, that agreement can be factored into the CAP review and approval process.

37) When will States have to stop claiming for school-based administration?

Answer:

On December 28, 2007, CMS issued a regulation in the Federal Register which eliminates reimbursement under the Medicaid program for costs of school-based administration and of transportation from home to school and back (CMS-2287-F). However, there's a six-month moratorium on CMS' ability to enforce the school-based rule, due to Public Law 110-173. This moratorium is scheduled to end June 30, 2008. For practical purposes, CMS intends to begin enforcing CMS-2287-F on the earliest date after June 30, 3008 that the school district begins a new school year or semester (but no later than September 30, 2008). After that date, school-based administrative activities will no longer be reimbursable.

The effective date for the TCM regulation (CMS-2237-IFC) is March 3, 2008. Section 441.18(c)(5)) of the TCM regulation (CMS-2237-IFC) states that activities meeting the definition in Sec. 440.169 for case management services and under the approved State plan cannot be claimed as administrative activities. Therefore, States do not have the option to claim any activities meeting the definition of case management services under the TCM rule as Medicaid administration. States will need to bring their school-based claiming programs into compliance with the TCM rule irrespective of the current moratorium on the school-based administrative claiming rule.

The relevant effective date is that of the TCM rule, March 3, 2008, rather than the implementation date associated with the school-based rule. States have to make changes to their Medicaid State plan to comply with the TCM rule for all populations, including school-based populations. So, to the extent activities formerly considered school-based administrative case management meet the definition of TCM under the final rule, the implementation dates and compliance requirements associated with the TCM rule would apply.

SERVICES FOR TRANSITIONING FROM MEDICAL INSTITUTIONS

38) What was the basis for the decision to go from 180 to 60 days for transitional case management?

Answer:

Due to an overwhelming number of comments on the time limits for transitioning an individual to the community, CMS is actively considering the impact of this provision.

39) Can the same case manager performing the transition to the community continue as case manager when the person leaves the institution?

Answer:

When an individual chooses to receive targeted case management services to assist with transitioning from a medical institution to the community, the case manager who serves the individual while in the institution may continue to serve the individual when he or she returns to the community. Please note that case management can only be provided by and reimbursed to community case management providers.

40) Can States claim for transitional TCM if the individual never leaves the institution, i.e. case management time was spent trying to secure an appropriate community placement but for a various reasons, the transition was not accomplished?

Answer:

Due to an overwhelming number of comments on the time limits for transitioning an individual to the community, CMS is actively considering the impact of this provision.

41) Are States that already have individuals transitioning to the community prior to the effective date of the regulation, subject to the 60 and 14 day timeframes?

Answer:

No. Those States that already have individuals transitioning to the community prior to the effective date of the regulation will have 180 days and will not be subject to the 60 and 14 day timeframes.

MANAGED CARE

42) Does this rule apply to Primary Care Case Management (PCCM) services?

Answer:

No. PCCM remains unchanged and is defined in section 42 CFR 440.168 of the Medicaid regulation.

43) If an individual is enrolled in a Managed Care Organization (MCO) which is paid a capitated rate that includes primary care coordination, can the individual receive targeted case management services outside of the MCO plan?

Answer:

Yes. A beneficiary enrolled in a MCO may receive services to coordinate his or her primary health care under the plan and also receive targeted case management services, as described

in the regulation, outside of the managed care plan. Receipt of targeted case management outside of the managed care plan may require adjustment of the managed care rate if it affects the actuarial value of services furnished by the managed care plan.

44) If an individual is enrolled in a Managed Care Organization (MCO) that is paid a capitated rate that includes primary care coordination, can the individual receive targeted case management services through a 1915(c) home and community based services waiver program?

Answer:

Yes. A beneficiary enrolled in a MCO may receive services to coordinate his or her primary health care under the plan and also receive targeted case management services, as described in the regulation, outside of the plan. Receipt of targeted case management outside of the managed care plan may require adjustment of the managed care rate if it affects the actuarial value of services furnished by the managed care plan.

45) Targeted case management typically has fee-schedule rates and the regulation does not address payment methodologies. Therefore, is it correct that the impact to managed care programs at the State level extends to ensuring any targeted case management services within managed care contracts are appropriately defined and priced?

Answer:

Yes. Managed care rates must reflect the cost of covered State plan case management services as defined in this regulation.

46) What changes will be required in capitation rates that include the State plan costs of case management services?

Answer:

As with other services, States may only include the cost of State-plan covered services, including HCBS, in developing the capitation rate for risk contracts. A State's actuary must use the state plan reimbursement methodology in determining the State plan cost of case management. If this adjustment results in a change in the portion of the rate intended to cover case management services, the rate should be revised accordingly.

47) What steps are States expected to take regarding capitated managed care programs to come into compliance with the new rule?

Answer:

All managed care contracts approved after the effective date of March 3, 2008, must be in compliance with the case management regulations.

48) Do the CM/TCM requirements apply to additional services provided through cost savings under 1915(b)(3) that result from more cost effective medical care?

Answer:

Section 1915(b)(3) services are provided out of the savings derived from managing the recipient's care and are not considered to be section 1905(a) services. Therefore, the requirements of the rule do not apply to these services. However, CMS will look at the specifics of each proposal to ensure that the approach is consistent with the rule.

CASE MANAGEMENT UNDER 1915(i) HCBS AS STATE PLAN OPTION

49) Does the regulation for Targeted Case Management apply to the 1915(i) State plan option?

Answer:

Yes. The policies set forth in CMS-2237-IFC will apply to the definition of case management services as included under section 1915(i) Home and Community Based Services as a State Plan Option.

50) Section 1915(i) requires an independent assessment. Please describe how States will ensure the independence of the assessor when the function is performed by any qualified provider (as assessment appears to meet the definition of case management under 42 CFR 440.169, and is therefore ineligible for administrative reimbursement).

Answer:

The independent assessment required pursuant to Section 1915(i) of the Social Security Act, is a stand-alone function that does not meet the requirements to be case management. Instead, it is a cost of administering the home and community-based benefit described in 1915(i), and the cost of the assessment may be claimed by the State as an administrative cost. This element, which is critical to the determination of eligibility for the 1915(i) benefit shall not be considered case management for the purposes of this regulation.

51) Are the following activities included in case management services, under 1915(i)? How should a State claim FFP for these activities? Plan development – service authorization Referral – account for costs for care coordinator

Answer:

When a State chooses to include case management services within a 1915(i) State plan HCBS benefit, the definition of the service must comport with section 42 CFR 440.169. Case management services are distinct from independent evaluation functions, described under section 1915(i)(1)(E)(i) and 1915(i)(1)(D)(i), which determine individuals' eligibility for the State Plan HCBS benefit. Reimbursement for case management services would be included under the section 1915(i) State plan HCBS benefit and be reimbursed as a service. A State may request reimbursement for independent evaluation, HCBS service plan development, eligibility determination and service authorization functions as administration.

REIMBURSEMENT

52) How much time will States have to redesign their MMIS system to accommodate the 15 minute units of case management?

Answer:

As CMS drafts the final rule, we intend to propose modifications of the 15-minute increment provision of the IFC. Specifically, we intend to recommend that the final regulation permit an extended timeframe for implementation as well as additional flexibility with respect to units of service. Please note that the 15-minute increment is not applicable for those States that opt to certify expenditures.

53) Are billable units only for face-to-face meetings?

Answer:

Billable units are for time spent delivering a case management service. That service may occur face-to-face with the beneficiary or may consist of telephone contacts or mail or e-mail contacts necessary to ensure that the beneficiary is served. Billable units may not be billed for such things as time spent traveling to a beneficiary to provide a case management service. However, the case management rate can factor in the cost of non-productive time associated with such things as case manager travel time and costs associated with mileage (in a cost-based payment methodology, by allocating such costs among all of the productive time increments). It may also include the actual writing of case notes, time documenting social history and writing the information gathered for the case file for the development of a specific care plan; and the gathering of information and the actual documentation. The state may also document non-productive time by providing evidence of State or private agency policies regarding sick leave, vacation leave, paid holidays and training requirements. Any other non-productive time must be documented via use of a CMS approved time study.

Several States have inquired as to what practices should be employed to ensure that no TCM provider is paid for more 15 minute units then they can feasibly deliver. One state intends to require documentation from each Target Case Manager and signed by his/her supervisor certifying the number of hours each day that a TCM was available to provide TCM services. The monthly summary of this data will be compared to the number of 15 minute units of service that were billed and paid. Billing units must be equal to or less than the number of available 15 minute units of time. This is an acceptable practice and States should also consider whether the rate has been developed to account for non-productive time, the number of billable units per case manager cannot be greater than the amount of productive time identified through the rate setting methodology. For example, if the rate is adjusted to account for one hour a day of non-productive time, the case manager (assuming an 8 hour day) could only bill for 28, 15 minute units which is equal to the 7 hours of productive time identified by the state in constructing the rate.

54) What constitutes an approved, statistically valid time study?

Answer

Recognizing the necessity of using a sample to develop claims, OMB Circular A-87 permits the use of "substitute systems" for allocating costs to federal awards in place of activity reports. Any such sampling methodology, or time study, must be approved by the funding agency (CMS). These time studies may utilize random moment sampling, case counts, or other quantifiable measures of employee effort, as long as they are deemed by CMS to be statistically valid and capture all paid time, even if it is not allowable to Medicaid. Required elements for a time study include the following: defining the sample universe, developing the activity codes, designing the sampling methodology, retaining required documentation, conducting training, ongoing oversight and monitoring, and developing a validation protocol. Surveys will not be sufficient. For private providers, states may wish to consider developing market-based rates as an alternative to documenting nonproductive time. Any such time study would be approved by CMS outside of the State plan amendment review process, and reference therein. The State's public assistance Cost Allocation Plan must also reference the CMS approved time study by way of amendment.

55) With respect to 441.18(a)(7) and "units of case management received", does there have to be a note in the file for every 15 minute code billed or can the documentation

requirements be met for 441.18(a)(7) by listing all the required information for a number of units, like a 2 hour service?

Answer: If a case management service lasts for 2 hours, the supporting documentation would indicate a service duration of 2 hours and a description of the activities that took place during that 2 hour period. Eight, 15 minute units would be billed.

56) What compliance activities will CMS initiate for States that have not implemented 15-minute increment payment methodology by June 30?

Answer:

It is our intent to modify this provision due to an overwhelming number of comments indicating the challenges for States to adopt this methodology and the time frame in which to do so.

57) Can CMS explain the 10 percent threshold in establishing overhead rates, and whether States may submit overhead rates larger than 10 percent?

Answer:

The CMS will entertain indirect rates higher than 10 percent, but the State will need to provide detailed documentation of the costs that are included in that rate and how it was developed.

58) What "additional documentation" will be necessary to support TCM claims when States submit their May budget estimates?

Answer:

The CMS is in the process of developing a format for States to use to provide documentation in support of their claims for TCM services for quarter ending June 30 documentation, conducting training, ongoing oversight and monitoring, and developing a validation protocol. Any such time study would be approved by CMS outside of the State plan amendment review process, and referenced therein. The State's public assistance Cost Allocation Plan must also reference the CMS approved time study by way of amendment.

TRIBAL ORGANIZATIONS

59) Are States subject to Tribal notice requirements prior to implementing the provisions in this regulation and do tribes need to be involved in and informed of the changes the State will need to make to apply the new case management requirements?

Presidential Executive order 13175 (November 6, 2000), states a federal requirement "…to establish regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications, to strengthen the United State's government-to-government relationships with Indian tribes, and to reduce the imposition of unfunded mandates upon Indian tribes."

Tribal entities have indicated that they are unfamiliar with the significant changes that will be enacted in the new TCM regulation and have concerns regarding the impact of this policy on the tribes. CMS has shared information on the rule with tribal organizations and will host a call with tribal organizations in order to provide an update on the implementation of the IFC. We will notify the State professional organizations of the time and logistics for this call.

In keeping with the requirements of the Executive Order, States should engage in discussions and notify in writing, all Federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State. States are strongly encouraged to provide for Tribal participation in the implementation of the substantive changes to the State case management policies and include Tribal organizations in discussions with CMS.