

**The Supplemental Appropriations Act, 2008  
&  
Implementation of CMS 2237 IFC: Targeted Case Management**

**Moratorium Language**

The Supplemental Appropriations Act, 2008, Pub. L. 110-252, was signed into law on June 30, 2008, at section 7001((a)(3), precludes CMS from taking any action prior to April 1, 2009 that would be more restrictive than applied on December 3, 2007 with respect to the provisions of CMS 2237-IFC. The law contained an exception for the portion of the regulation as it relates directly to implementing section 1915(g)(2)(A)(ii) of the Social Security Act (the Act) as amended by section 6052 of the Deficit Reduction Act (Public Law 109-171), through the definition of case management services and targeted case management services contained in proposed section 440.169 of title 42, Code of Federal Regulations, but only to the extent such portions are not more restrictive than the policies contained in following issuances:

- A July 25, 2000 State Medicaid Director (SMD) letter which summarizes CMS policy clarifications designed to support State efforts to transition individuals from institutions and expand availability of home and community-based services; and
- A January 19, 2001 letter to State Child Welfare and State Medicaid Directors which clarifies policy on targeted case management services under the Medicaid program as it relates to an individual's participation in other social, educational, or other programs.

**Current Case Management Policy**

Below is an initial guide for use by States regarding current CMS case-management policy in light of the moratorium. This document does not represent a comprehensive list of all relevant Medicaid policy issuances, but is designed to assist States in assessing the impact of the exception included in the CMS 2237-IFC moratorium on case management services included in State Plans or recent State Plan Amendment (SPA) submittals.

In general, section 6052 of the Deficit Reduction Act of 2005 and CMS guidance issued prior to December 4, 2007, through State Medicaid Director letters, Associate Regional Administrators' letters, the State Medicaid Manual and other issuances, is in effect. States continue to be at risk for all claims submitted that are not in compliance with these policies. State Plan Amendments (SPAs) that do not comply with section 1902(a) of the Act are subject to disapproval. CMS is committed to continuing to work with States by providing technical assistance to ensure full compliance with current statute, regulation, and policy.

**Definitions, requirements and policies that remain in effect during the moratorium include the following:**

1. Medicaid case management services are defined as services that assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

2. Case management services include the following allowable activities:
  - i. assessment,
  - ii. development of a care plan,
  - iii. referral, and
  - iv. monitoring and follow-up.
3. Medicaid case management services do not include payment for the provision of direct services (medical, educational, or social) to which the Medicaid eligible individual has been referred. For example, if a child has been referred to a State foster care program, activities performed by the foster care case worker that relate directly to the provision of foster care services cannot be covered as case management. Since these activities are a component of the overall foster care service to which the child has been referred, the activities do not qualify as case management.
4. Federal Financial Participation (FFP) is available as a case management activity for contacts with non-eligible or non-targeted individuals when the purpose of the contact is directly related to the management of the eligible individual's care. Contacts with non-eligibles and non-targeted individuals that relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care cannot be billed to Medicaid.
5. In accordance with Medicaid third party liability policy, Medicaid would only be liable for the cost of otherwise allowable case management services if there are no other third parties liable to pay.
6. Any reimbursement methodology for TCM services must reflect CMS policies related to the development of economic and efficient rates.
7. FFP is available for the provision of case management services during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition. Consistent with guidance in the July 2000 SMD letter, States may seek reimbursement for transitional case-management regardless of whether the resident successfully transitions.
8. Prior policy related to administrative activities as described in SMDs dated July 25, 2000 and 1994 is in effect. CMS will continue to review States' Cost Allocation Plans (CAPs) and administrative claims to ensure compliance with prior administrative claiming guidance.
9. Consistent with "efficiency and economy" provisions under section 1902(a)(30)(A) of the Act, prior policy mandates that any claims (including those related to case-management services) must not duplicate payments:
  - i. made to public agencies or private entities under the State Plan,
  - ii. other services or program authorities; or
  - iii. for administrative expenditures.

In light of the moratorium, CMS will not enforce the following IFC provisions:

1. The requirement that case management services be comprehensive, as specified in section 441.18(a)(5).
2. The requirement for the development of a specific care plan meeting certain requirements, as specified in section 440.169(d)(2).
3. The requirement that case-management services be provided by a single case manager as specified in section 441.18(a)(5) of the IFC.

4. The case record documentation requirements as specified in section 441.18(a)(7) of the IFC.
5. A 60 and 14-day limit on the number of days States may claim for the provision of case-management to institutionalized persons to facilitate transition as specified in section 441.18(A)(8)
6. A prohibition on claims submitted for residents that do not successfully transition from institutions to community settings as specified in section 441.18(A)(8).
7. A prohibition on the use of workers of other programs to provide Medicaid case-management. CMS will continue to review State Plan Amendments and financial documentation to ensure claims do not represent direct delivery of non-Medicaid services.
8. Requirement for billing in 15 minute increments. Although CMS will not require states to bill for TCM in 15 minute units, the provisions of section 1902(a)(30)(A) of the Act mandate that we continue to review rates to ensure that they are economic and efficient. Therefore, CMS will continue to require States, for any rate and billing unit proposed, to demonstrate that the rate does not reimburse for non-Medicaid costs or services and the rate accurately reflects the cost of services that beneficiaries actually receive.

#### **Status of State Plan Amendments (SPAs)**

While the moratorium impacts certain provisions of the IFC, States must comply with current case management policy and the provisions set forth in the DRA and prior guidance – as summarized above. With the issuance of the IFC and the establishment of a March 3, 2008 effective date, CMS encouraged States to submit necessary SPAs by June 30, 2008 to secure an effective date of April 1, 2008. States have the option to withdraw pending these SPAs. However, passage of the moratorium does not require or necessitate a SPA withdraw. Those provisions set forth in the IFC which were based on prior CMS policy, statute, and regulation, are not affected by the moratorium and are in effect.

We will work with States to determine how best to proceed with the review of SPAs that were recently submitted in accordance with the IFC. We recognize States may want to modify those submissions as a result of the moratorium. We hope that any modifications can be addressed during the standard SPA review and “Request for Additional Information (RAI)” process. To facilitate these reviews, CMS is issuing a revised TCM SPA outline based on the moratorium provisions that States will have the option to use (attached). We would advise that FFP is at risk for States that have not yet submitted SPAs to come into compliance with the case management requirements not affected by the moratorium.

#### **TCM and the Home and Community-Based Waiver Program**

In light of the moratorium:

1. CMS will not require States to include language in their amendment and renewal waivers indicating a commitment for rule compliance.
2. New waivers submitted for consideration will be judged in accordance with the policies and procedures in effect as of December 3, 2007..
3. CMS will continue to monitor 1915(c) waiver programs to ensure that the services provided through the waiver are not integral to another program, such as foster care and juvenile justice, since this policy predates December 3, 2007..
4. CMS will continue to ensure that individuals are afforded comprehensive care plans with safeguards against duplication of services, since this policy predates December 3, 2007.
5. Case management services provided pursuant to 1915(c) waivers must adhere to the requirements of Section 1902(a)(23) related to the free choice of all willing and qualified providers, since these requirements predate December 3, 2007..

Questions regarding the Supplemental Appropriations Act, 2008 and its implications for CMS 2237-IFC (Targeted Case Management) may be directed to Linda Peltz at 410-786-3399 or Maria Reed at 410-786-2255.