

The CMS Medicaid Targeted Case Management Rule: Implications for Special Needs Service Providers and Programs

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This issue brief examines the CMS targeted case management rule, issued December 4, 2007, in the context of people with complex health needs who receive services from programs that specialize in community-based care management.¹ Following a brief overview of the case management amendments contained in the Deficit Reduction Act, this analysis summarizes the key elements of the CMS regulation² and considers its implications in the context of specialized services, providers, and programs.

Background

Case management is commonly understood to consist of services that assist eligible beneficiaries in securing medical and other health services necessary to appropriate care and treatment.³ Case management is not the direct provision of care and services, but instead is a separate and reimbursable class of services under Medicaid that for specific beneficiaries, identifies necessary services, assists in locating the services, identifies providers, and monitors the provision of care. Services offered through case management transcend Medicaid reimbursable care and services and can include educational, social, and uncovered health services.

Case management historically has been understood to be part of the EPSDT administrative service requirements. Case management services also were understood to be a separate administrative activity under Medicaid provisions governing the relationship between Medicaid agencies and state maternal and child health agencies, essentially as a form of public health nursing.⁴

Case management has existed as a separate, reimbursable class of medical assistance since 1986.⁵ Congressional amendments initially made targeted case management (TCM) services (that is, case management services targeted to specific population subgroups) a payable class of medical assistance service when furnished as part of state waiver programs under §1915.⁶ Congress subsequently amended Medicaid to permit states to furnish targeted case management services as a coverage option, regardless of whether coverage was offered in connection with a waiver program. (Previous legislation enacted in 1981 recognized case management as a separate payable activity in states

¹ 72 Fed. Reg. 68077-68093 (Dec. 4, 2007). The effective date of the rules is March 3, 2008.

² The information presented in this brief is based on the CMS TCM regulation as well as CMS' *Case Management Questions and Answers* document, released on April 21, 2008. Available at www.cms.hhs.gov/deficitreductionact/medicaidcasemanagement.

³ C. Binder, *Medicaid Targeted Case Management Benefits* (CRS, March 27, 2008) p. 1.; CMS, *Optional State Plan Case Management Services*, 72 Fed. Reg. 68075, 68076.

⁴ S. Rosenbaum, *CMS Medicaid Regulations: Implications for Children With Special Health Care Needs* (First Focus, March, 2008). Available at http://www.firstfocus.net/pages/3379/New_Report_Indicates_Medicaid_Rules_Would_Hurt_Special_Needs_Children.htm (accessed April 13, 2008).

⁵ CMS, *Optional State Plan Case Management Services*, 72 Fed. Reg. 68076.

⁶ *Id.*

operating primary care case management systems,⁷ but the 1981 amendments did not adopt case management as a separate service class).

The Congressional Research Service (CRS) notes that almost all states cover TCM services. CRS also reports that total federal and state Medicaid expenditures for TCM services stood at \$2.9 billion in FY 2005, with some 2.7 million beneficiaries and an average expenditure of slightly more than \$1,050 per beneficiary.⁸

Immediately prior to leaving office, the Clinton Administration issued a State Medicaid Directors⁹ (SMD) letter in 2001 outlining TCM requirements in a foster care context; CRS notes that the guidance also has been cited as applicable to other TCM arrangements. The SMD letter specified coverage and billing arrangements, as well as the breadth of state flexibility. The letter contained the following specific provisions regarding state use of TCM financing:

- Permitted states to use participation in other public programs as the basis for targeting, but required that TCM costs be limited to TCM, as opposed to costs incurred in delivering a social or other benefit.¹⁰
- Allowed states to use TCM to supplement services to Medicaid-eligible people, even when such activities are also “embedded in another program.”¹¹
- Specified that allowable activities included assessment of need, case planning, referral and linkage, and monitoring and follow-up, but excluded the direct delivery of underlying medical, educational, or social services.¹²
- Permitted contact with Medicaid-ineligible individuals or Medicaid-enrolled beneficiaries who are not included in the TCM sub-group when the purpose of the contact and interaction was directly related to the management of care.¹³
- Clarified that normal third-party liability recovery (TPL) rules apply to TCM services, but that whether or not a separate public program could be considered a liable third party would depend on the interpretation of the scope of the program by the public agency in charge of the program.¹⁴

CMS activities under the Bush Administration subsequent to the issuance of the 2001 letter indicated a departure from the terms of the letter, specifically denying state plan practices that appeared to be permissible under the terms of the 2001 letter.¹⁵

The Deficit Reduction Act of 2005

Section 6052 of the Deficit Reduction Act (DRA)¹⁶ addressed TCM, as follows:

⁷ Id.

⁸ Targeted Case Management Benefits, op. cit. p. 2.

⁹ Health Care Financing Administration, State Medicaid Directors Letter SMDL 01-013 issued January 2001. Available at <http://www.cms.hhs.gov/smdl/downloads/smd011901c.pdf> (accessed April 13, 2008).

¹⁰ Id.

¹¹ Id.

¹² Id.

¹³ Id.

¹⁴ Id.

¹⁵ Medicaid Targeted Case Management Benefits, op. cit. p. 4.

¹⁶ P.L. 109-171.

- Codified the 2001 letter, while also clarifying that TCM funds cannot be used to furnish assistance to people ineligible for TCM coverage (an issue addressed in the SMD letter).
- Clarified the applicability of TPL recovery to TCM medical assistance expenditures, but did not suggest an expansion of CMS powers to independently determine whether separate federal or state legislative authorities not under CMS' administrative authority treat TCM as a payable service.
- Specified the application of federal cost allocation principles when an activity was shared with another program, but without specifying which other programs shared TCM functions.
- Did not adopt the “intrinsic element” test used by CMS¹⁷ as a basis for disallowing TCM expenditures on behalf of individuals receiving services under multiple public programs.
- Specified publication of a TCM rule on an interim final basis.

The CMS Regulation

The CMS regulation issued in December 2007 expanded on the DRA provisions, amplifying the provisions to include requirements and prohibitions articulated by the agency in earlier post-1981 rulings and disallowances but not included by Congress in the TCM amendments. The rule, which was not subject to the moratorium on certain CMS-issued Medicaid regulations enacted by Congress at the end of 2007,¹⁸ applies to all TCM expenditures whether delivered under a waiver or as a state plan option.¹⁹

The key elements of the rule are as follows:

- Specifies, as did earlier CMS rulings,²⁰ that because TCM is a form of medical assistance, Medicaid's freedom of choice requirements apply, although the state agency may limit choice to providers deemed qualified to furnish care to the TCM population.²¹
- Defines case management services as services that assist individuals “eligible under the state plan who reside in a community setting or are transitioning to a community setting” in gaining access to needed medical, social, educational and other services.”²² The effect is to eliminate TCM as an allowable service for people in institutions. The rule does permit TCM during the last 14-60 days of an inpatient stay, depending on the length of the stay,²³ while prohibiting TCM for individuals transitioning into community settings from institutions for mental diseases (IMDs).²⁴
- Specifies TCM activities as specified procedures (taking client history, identifying the individual's needs, and gathering documents and information to form a complete assessment); development and periodic revision of a specified care plan; referral and related activities; and monitoring and follow-up activities to assure that services are performed as specified in the care

¹⁷ In Congressional testimony in 2005, Dennis Smith, then director of the Center for Medicaid and State Operations (CMSO) recommended legislative amendments to prohibit federal Medicaid payments for TCM services that were “intrinsic elements” of other programs. His testimony did not define the term, nor is the term defined in the interim final rule.

¹⁸ Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173).

¹⁹ Medicaid Targeted Case Management Benefits, op. cit. p. 6.

²⁰ Id.

²¹ 42 C.F.R. §§441.18(a)(1) and 441.51, as added.

²² 42 C.F.R. §441.169(a) as added.

²³ According to the April 21, 2008 *Case Management Questions and Answers* document, CMS is actively considering the impact of this provision.

²⁴ 42 C.F.R. §441.169(c) as added. Because CMS considers inpatient psychiatric care for children under 21 to be care in an IMD rather than care furnished in an IMD exception, TCM would be unavailable to these children, presumably.

plan²⁵ or performed as part of a comprehensive assessment and periodic reassessment of the need for medical, educational, social or other services.

- Specifies that TCM can include contacts with ineligible individuals if “directly related” to the activities that are encompassed in TCM.²⁶
- Specifies that TCM can be limited to “groups specified by the state” or “certain geographic areas within a state.”²⁷
- Prohibits TCM from being used to “restrict access” under the state plan²⁸ and specifies that case management providers may not exercise the state agency’s authority “to authorize or deny the provision of other services under the plan.”²⁹ (“We . . . 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.”)³⁰
- Prohibits states from compelling people to receive TCM as a condition of receiving other Medicaid services, or vice versa.³¹
- Requires that states indicate in their plan that “case management services. . . will not duplicate payments made to public agencies or private entities under the state plan and other program authorities.”³²
- Requires case management to be a one-on-one activity and restricts individuals to one case manager.³³
- Sets up extensive provider recordkeeping requirements for individuals receiving TCM services³⁴ and requires separate plan amendments for each class of case management assistance group.³⁵
- Bars case management payments when “any of the following conditions exist:”
 - » First, case management activities are an integral component of another Medicaid service such as physician services.³⁶ (The Preamble notes the following in relation to managed care contracts: “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...services when the individual is eligible for these services.” The Preamble does not explain whether the “integral component” rule runs to the contract itself, that is, whether case management is integral to managed care entities, or to specific services, such as physician services, contained within the contract.)³⁷

²⁵ 42 C.F.R. §441.169(d)(1)-(4) as added.

²⁶ 42 C.F.R. §441.169(e) as added.

²⁷ 42 C.F.R. §440.250 as added.

²⁸ 42 C.F.R. §441.18(a)(2).

²⁹ 42 C.F.R. §441.18(a)(6).

³⁰ 72 Fed. Reg. 68084.

³¹ 42 C.F.R. §441.18(a)(3).

³² 42 C.F.R. §441.18(a)(4).

³³ 42 C.F.R. §441.18(a)(5).

³⁴ 42 C.F.R. §441.18(a)(7).

³⁵ 42 C.F.R. §441.18(a)(8).

³⁶ 42 C.F.R. §441.18(c)(1).

³⁷ 72 Fed. Reg. 68065.

At the same time, the rule specifically prohibits the use of bundled payments.³⁸ (The rule states the following: “...a state cannot employ a methodology or rate that result in payment for a bundle of services. Per diem rates, weekly rates, and monthly rates represent a bundled payment methodology that is not consistent with section 1902(a)(30)(A) of the Act, which requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. A bundled payment methodology exists when a state pays a single rate for more than one service furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or otherwise available rates. Since these bundled (daily, weekly or monthly) rates are not reflective of the actual types or numbers of services provided or the actual costs...they are not accurate or reasonable payments...”).³⁹

- » Second, the case management activities constitute the direct delivery of underlying medical, educational, social or other service. This exclusionary test differs from the “integral component” since it rests on the assumption that a service billed as “case management” actually falls into another medical assistance service class, such as a preventive service or a rehabilitation or nurse practitioner service.
 - » Third, the activities are “integral to the administration of foster care programs.” Note: The concept of “integral to” is not defined.
 - » Fourth, the activities are integral to the administration of another non-medical program. Note: The concept of “integral to” is not defined.⁴⁰
- Bars claiming as an administrative cost any activities falling within the definition of targeted case management.⁴¹

It is important to note that the rule prohibits the use of TCM to help move an individual from an excluded setting back into the community where Medicaid coverage will resume. Thus, the Preamble gives examples of individuals who are leaving the criminal justice system or an IMD, who presumably possess significant disabilities, and who will need to be eased into the community. These individuals are considered under the rule to be excluded from the permissible TCM payment system.⁴² Similarly, the Preamble contains a lengthy and ambiguous discussion of how Medicaid and education programs can share in the cost of case management for children receiving services through both programs. The discussion does not provide a clear explanation of the “intrinsic element” exclusion.

Applications of the TCM Rule Using Common Case Management Elements

In recent years, states have pursued programs that target the aged, blind, and disabled (ABD) and/or Supplemental Security Income (SSI) eligible beneficiaries as a way to more appropriately manage the care needs of these complex populations. Many of these programs will potentially be affected by the TCM rule. The following chart illustrates how common elements of patient-centered programs that contain a case management function may be affected by the TCM rule.

³⁸ 42 C.F.R. §441.18(a)(7).

³⁹ 72 Fed. Reg. 680640-68065. This would seem to preclude the inclusion of case management in a specialized managed care contract because it represents a bundling on a per capita basis by enrollee member months.

⁴⁰ 42 C.F.R. §441.18(b)(4) Paradoxically, the rule also requires the use of federal cost allocation principles when TCM costs are to be borne by two or more federal programs. 42 C.F.R. §441.18(d).

⁴¹ 42 C.F.R. §441.18(b)(5).

⁴² 72 Fed. Reg. 68085-86.

Elements Common to Case Management Programs Serving Beneficiaries with Complex Health Needs	Potential Effects of TCM Rule
<p>Care Coordination Availability: Care coordination is commonly available on a 24/7 basis.</p>	<p>This degree of availability may likely end, since the same care manager would effectively need to be on duty on a 24/7 basis.</p>
<p>Care Manager as a Gatekeeper: Care managers coordinate multiple services, including medical services and non-medical services such as: vocational, educational, housing, social services, and recreational.</p>	<p>The regulation prohibits programs from combining utilization management and case management. According to CMS' Question and Answers document, the state can take into account a case manager's recommendation, but cannot rely solely on case managers' decisions about the determination of medical necessity or prior authorizations.</p>
<p>Care Plans: A care plan is often required for each beneficiary. If a beneficiary accesses care from both physical and behavioral health providers, she/he may have multiple care plans in place.</p>	<p>The development of multiple care plans may likely be prohibited, as would the care team that is responsible for coordinating the plans.</p> <p>If the client is also receiving other public services, TCM might be excluded altogether under the "intrinsic element" or "public program" exclusion.</p> <p>Unit cost payment arrangements and recordkeeping requirements may also apply.</p>
<p>Care Teams: Each beneficiary is typically assigned a care manager (or a care team) who assists with coordination of primary and acute services (and LTC services, if applicable).</p>	<p>Although CMS recognizes that a single case manager may need to consult with other providers with specialized expertise,⁴³ care teams appear to be prohibited by the single case manager rule. All service units may need to be disaggregated into their care functions and their case management functions. States would have up to one year after their next legislative session to comply with this provision.</p>
<p>Cross-Service Coordination: Care managers often make housing referrals and assist with relocation. Additionally, care managers are often responsible in assisting the beneficiary with pharmaceutical management, routine monitoring of her/his condition, and referrals to additional ancillary services.</p>	<p>Assistance with housing would be permitted unless individuals qualify for assistance from housing authorities or housing programs, in which case TCM payments would risk exclusion under the "intrinsic element" or "public program" exclusion.</p> <p>Medication management is arguably utilization management or an intrinsic element of prescribing and dispensing pharmaceutical products. Because the activity is an element of underlying medical care, TCM payments would be prohibited.</p>
<p>Health Assessments: Beneficiaries undergo health assessments (questions may include: functional assessments, overall health, urgent care needs). If the assessments are very clinically-focused, a care manager, nurse, or physician will conduct it.</p>	<p>Costs associated with the health assessment would need to be separately billed as an underlying form of medical assistance.</p>
<p>Member Education: Care managers may also provide disease-specific or other types of member education to their beneficiaries.</p>	<p>Such counseling constitutes a preventive health care service and arguably is therefore excluded as part of an underlying medical assistance service class. Unit cost payment arrangements would be needed.</p>

⁴³ April 21, 2008 CMS Case Management Questions and Answers document.

Elements Common to Case Management Programs Serving Beneficiaries with Complex Health Needs	Potential Effects of TCM Rule
<p>Multiple Care Managers: A beneficiary will have multiple care managers, particularly if she/he is under mental health and physical health treatment. Depending on the beneficiary’s needs, the care manager may be responsible for linking to behavioral health providers as well as making sure screenings, referrals, and coordination of treatment takes place.</p>	<p>Multiple care managers would be prohibited, whether integrated into a team or paid separately.</p>
<p>Person-Centered Care Planning: Care planning involves the beneficiary in order to facilitate self-responsibility for her/his health status.</p>	<p>Care planning involving a beneficiary is permitted, unless the beneficiary is also receiving other social or educational services, in which case all costs associated with case management may be excluded under the “intrinsic element” exclusion.</p>
<p>Transitioning People from Institutional Settings: People who reside in institutions and are transitioning into community settings may need ongoing case management.</p>	<p>According to the rule, TCM would be prohibited for people who are transitioning except for the 14-60⁴⁴ day time period immediately preceding their discharge.⁴⁵</p>

Conclusion

This analysis reviews CMS’ TCM regulation and illustrates its potential application to “real world” programs that employ case management. These examples underscore the potential power of the rule to significantly reduce the availability of TCM services on numerous grounds. The CMS rule could prohibit the use of:

- Multiple care managers/care teams;
- Combined utilization management and case management;
- TCM payments to individuals receiving assistance under multiple programs; and
- TCM payments for services that are “intrinsic elements” of underlying medical assistance services.

In addition, the CMS rule also prohibits the exclusions applied by the “intrinsic element” and “public program” tests. Furthermore, while the TCM rule contemplates contracts with integrated delivery organizations that furnish managed care, its prohibition against bundled payments may not allow the inclusion of TCM costs in capitation rates or paid on a per member per month basis. Finally, the introduction of a unit payment system and the imposition of extensive recordkeeping (i.e., in addition to data collected from managed care organizations as a routine reporting requirement) would appear to add significant new administrative requirements to managed care contracts that include TCM as a payable service.

Case management is an essential element of efforts to improve the quality of care delivered to people with complex health needs. The 2007 CMS regulation — to a significantly greater degree than either the 2001 federal guidelines or the DRA — appears to limit the availability of federal financial participation for this critical service for people with complex needs.

⁴⁴ Prior to the rule, the time period was 180 days.

⁴⁵ According to the April 21, 2008 *Case Management Questions and Answers* document, CMS is actively considering the impact of this provision.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit organization dedicated to improving health care quality and cost effectiveness for low-income populations and people with chronic illnesses and disabilities. We work directly with states and federal agencies, health plans, and providers to develop innovative programs that better serve people with complex and high-cost health care needs. For information, visit www.chcs.org.

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