

CCQC

**Train the Trainer: Case
Management**

State and Federal Guidance

CASE MANAGEMENT SERVICES					
CPT®/HCPCS PROCEDURE CODE			PROCEDURE CODE DESCRIPTION		
T1016			Case management, each 15 minutes		
SERVICE DESCRIPTION			MINIMUM DOCUMENTATION REQUIREMENTS		
<p>Services designed to assist and support a consumer to gain access to needed medical, social, educational, and other services. Case management includes:</p> <ul style="list-style-type: none"> • Assessing service needs – consumer history, identifying consumer needs, completing related documents, gathering information from other sources; • Service plan development – specifying goals and actions to address consumer needs, ensuring consumer participation, identifying a course of action; • Referral and related activities to obtain needed services – arranging initial appointments for consumer with service providers/informing consumer of services available, addresses and telephone numbers of agencies providing services; working with consumer/service providers to secure access to services, including contacting agencies for appointments/services after initial referral process; and • Monitoring and follow-up – contacting consumer/others to ensure consumer is following the agreed upon service plan and monitoring progress and impact of plan. 			<ul style="list-style-type: none"> • Consumer demographic information • Start and end time/duration • Each contact with and on behalf of consumer • Nature and extent of service • Date and place of service delivery • Mode of contact (telephone/face-to-face) • Issues addressed (adult living skills, family, income/ support, legal, medication, educational, housing, interpersonal, medical/dental, vocational, other basic resources) • Consumer's response • Progress toward service plan goals and objectives • Case Manager's dated signature, degree, title/position • Type of activity and specific functions <ul style="list-style-type: none"> ○ Assessment (consumer history, identifying consumer needs, completing related documents, gathering information from other sources) ○ Service plan development (specify goals and actions to address consumer needs, ensure participation of consumer, identify course of action) ○ Referral (arranging initial appointments for consumer with service providers/informing consumer of services available, addresses and telephone numbers of agencies providing services; working with consumer/service providers to secure access to services, including contacting agencies for appointments/services after initial referral process) ○ Monitoring and follow-up (contacting consumer/others to ensure consumer is following agreed upon service plan and monitoring progress and impact of plan) 		
NOTES			EXAMPLE ACTIVITIES		
<p><i>Case management involves linking the consumer to the direct delivery of needed services, but is not itself the direct delivery of a service to which the consumer has been referred.</i> Case management does not include time spent transporting the consumer to required services/time spent waiting while the consumer attends a scheduled appointment. However, it does include time spent participating in an appointment with the consumer for purposes of referral and/or monitoring and follow-up.</p>			<ul style="list-style-type: none"> • Assessing the need for service, identifying and investigating available resources, explaining options to consumer and assisting in application process • Contact with consumer's family members for assistance helping consumer access services 		
APPLICABLE POPULATION(S)			UNIT		DURATION
<input checked="" type="checkbox"/> Child (0-11)	<input checked="" type="checkbox"/> Young Adult (18-20)	<input checked="" type="checkbox"/> Adult (21-64)	<input type="checkbox"/> Encounter	<input checked="" type="checkbox"/> 15 Minutes	Minimum: 15 Minutes Maximum: N/A
<input checked="" type="checkbox"/> Adol (12-17)		<input checked="" type="checkbox"/> Geriatric (65+)	<input type="checkbox"/> Day	<input type="checkbox"/> 1 Hour	
ALLOWED MODE(S) OF DELIVERY			PROGRAM SERVICE CATEGORY(IES)		
<input checked="" type="checkbox"/> Face-to-Face	<input checked="" type="checkbox"/> Individual	<input checked="" type="checkbox"/> On-Site	<input checked="" type="checkbox"/> SP (HE)	<input checked="" type="checkbox"/> Home-Based (SE)	<input checked="" type="checkbox"/> Voc (HJ)
<input type="checkbox"/> Video Conf (GT)	<input type="checkbox"/> Group (HQ)	<input checked="" type="checkbox"/> Off-Site	<input checked="" type="checkbox"/> School (TJ)	<input checked="" type="checkbox"/> ICM (SK)	<input checked="" type="checkbox"/> Clubhouse (HB)
<input checked="" type="checkbox"/> Telephone	<input checked="" type="checkbox"/> Family (HR/HS)		<input type="checkbox"/> Other SP (TG)	<input checked="" type="checkbox"/> ACT (HK)	<input checked="" type="checkbox"/> Recovery (TS)
			<input checked="" type="checkbox"/> Residential (SC)	<input checked="" type="checkbox"/> Respite (SY)	<input checked="" type="checkbox"/> Prev/EI (HT)
STAFF REQUIREMENTS					
<input type="checkbox"/> Peer Specialist	<input checked="" type="checkbox"/> Unlicensed Master's Level (HO)	<input checked="" type="checkbox"/> Unlicensed EdD/PhD/PsyD (HP)	<input type="checkbox"/> QMAP	<input checked="" type="checkbox"/> LPN/LVN (TE)	<input checked="" type="checkbox"/> RxN (SA)
<input checked="" type="checkbox"/> Bachelor's Level (HN)	<input checked="" type="checkbox"/> LCSW (AJ)/LSW/LMFT/ LPC	<input checked="" type="checkbox"/> Licensed EdD/PhD/PsyD (AH)	<input checked="" type="checkbox"/> Psych Tech	<input checked="" type="checkbox"/> RN (TD)	<input checked="" type="checkbox"/> PA (PA)
				<input checked="" type="checkbox"/> APRN (SA)	<input checked="" type="checkbox"/> MD/DO (AF)
PLACE OF SERVICE (POS)					
<input checked="" type="checkbox"/> CMHC (53)	<input checked="" type="checkbox"/> ACF (13)	<input checked="" type="checkbox"/> Hospice (34)	<input checked="" type="checkbox"/> Shelter (04)	<input checked="" type="checkbox"/> Inpt Hosp (21)	<input checked="" type="checkbox"/> Pharmacy (01)
<input checked="" type="checkbox"/> Office (11)	<input checked="" type="checkbox"/> Cust Care (33)	<input checked="" type="checkbox"/> ICF-MR (54)	<input checked="" type="checkbox"/> SNF (31)	<input checked="" type="checkbox"/> Inpt PF (51)	<input checked="" type="checkbox"/> Prison/CF (09)
<input checked="" type="checkbox"/> Mobile Unit (15)	<input checked="" type="checkbox"/> Grp Home (14)	<input checked="" type="checkbox"/> NF (32)	<input checked="" type="checkbox"/> Temp Lodging (16)	<input checked="" type="checkbox"/> ER (23)	<input checked="" type="checkbox"/> School (03)
	<input checked="" type="checkbox"/> Home (12)	<input checked="" type="checkbox"/> PRTC (56)		<input checked="" type="checkbox"/> PF-PHP (52)	<input checked="" type="checkbox"/> Other POS (99)

Case Management Definition in 2006 Deficit Reduction Act

SEC. 6052. REFORMS OF CASE MANAGEMENT AND TARGETED CASE MANAGEMENT.

(a) IN GENERAL.—Section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) is amended by striking paragraph (2) and inserting the following:

“(2) For purposes of this subsection:

“(A)(i) 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.”“(II) Such term includes the following:

“(I) **Assessment** of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

“(aa) Taking client history.

“(bb) Identifying the needs of the individual, and completing related documentation.

“(cc) 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.

“(II) **Development of a specific care plan** based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual’s authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

“(III) **Referral and related activities** to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

“(IV) **Monitoring and followup activities**, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—

“(aa) whether services are being furnished in accordance with an individual’s care plan;

“(bb) whether the services in the care plan are adequate; and

“(cc) whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

“(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.

“(B) 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.

“(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not part of the target population specified in the State plan, such contacts—

“(A)are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual’s care; and

“(B)are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual’s needs and care.

“(4)(A) In accordance with section 1902(a)(25), Federal financial participation only is available under this title for case management services or targeted case management 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.

“(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A-87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.

“(5) Nothing in this subsection shall be construed as affecting the application of rules with respect to third party liability under programs, or activities carried out under title XXVI of the Public Health Service Act or by the Indian Health Service.”

(b) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendment made by subsection (a) which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2006.

- (1) Are furnished to outpatients;
 - (2) Are furnished by or under the direction of a physician or dentist; and
 - (3) Are furnished by an institution that—
 - (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
 - (ii) Meets the requirements for participation in Medicare as a hospital; and
 - (4) May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of “outpatient hospital services” those types of items and services that are not generally furnished by most hospitals in the State.
- * * * * *

§ 440.169 [Amended]

- 7. Section 440.169 is amended by removing and reserving paragraph (c).
- 8. Section 440.170(a)(1) is revised to read as follows:

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(a) *Transportation.* (1) “Transportation” includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

* * * * *

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

- 9. The authority citation for part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).
- 10. Section 441.18 is amended by removing and reserving paragraphs (a)(5), and (a)(8)(vi); removing (a)(8)(viii); and revising paragraph (c) to read as follows:

§ 441.18 Case management services.

* * * * *

(c) Case management does not include, and FFP is not available in expenditures for, services defined in § 441.169 of this chapter when 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 for foster care programs, services such as, but not limited to, the following:

- (1) Research gathering and completion of documentation required by the foster care program.

- (2) Assessing adoption placements.
 - (3) Recruiting or interviewing potential foster care parents.
 - (4) Serving legal papers.
 - (5) Home investigations.
 - (6) Providing transportation.
 - (7) Administering foster care subsidies.
 - (8) Making placement arrangements.
- * * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medical Assistance Program.)

Dated: June 5, 2009.
Charlene Frizzera,
Acting Administrator, Centers for Medicare & Medicaid Services.
 Approved: June 17, 2009.
Kathleen Sebelius,
Secretary.
 [FR Doc. E9–15345 Filed 6–29–09; 8:45 am]
BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 433

[CMS–2275–F2]

RIN 0938–AP74

Medicaid Program; Health Care-Related Taxes

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Final rule.

SUMMARY: This rule finalizes our proposal to delay enforcement of certain clarifications regarding standards for determining hold harmless arrangements in the final rule entitled, “Medicaid Program; Health Care-Related Taxes” from the expiration of a Congressional moratorium on enforcement from July 1, 2009 to June 30, 2010.

DATES: *Effective Date:* These regulations are effective on July 1, 2009.

FOR FURTHER INFORMATION CONTACT: Stuart Goldstein, (410) 786–0694.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1903(w) of the Social Security Act (the Act) provides for a reduction of Federal Medicaid funding based on State health care-related taxes unless those taxes are imposed on a permissible class of health care services; broad based, applying to all providers within a class; uniform, such that all providers within a class must be taxed

at the same rate; and are not part of hold harmless arrangements in which collected taxes are returned, whether directly or indirectly. A similar hold harmless restriction applies to provider-related donations. Section 1903(w)(3)(E) of the Act specifies that the Secretary shall approve broad based (and uniform) waiver applications if the net impact of the health care-related tax is generally redistributive and the amount of the tax is not directly correlated to Medicaid payments. The broad based and uniformity requirements are waivable through a statistical test that measures the degree to which the Medicaid program incurs a greater tax burden than if these requirements were met. The permissible class of health care services and hold harmless requirements cannot be waived. The statute and Federal regulation identify 19 permissible classes of health care items or services that States can tax without triggering a penalty against Medicaid expenditures.

On February 22, 2008, we published a final rule entitled, “Medicaid Program; Health Care-Related Taxes” (73 FR 9685). This final rule amended provisions governing the determination of whether health care provider taxes or donations constitute “hold harmless” arrangements, codified statutory changes to the indirect guarantee threshold test and the definition of the class of managed care organization services, and deleted certain obsolete transition period regulatory provisions. The rule codified the reduction in the indirect guarantee threshold test in order to reduce the allowable amount that can be collected from a health care-related tax for the period of January 1, 2008, through September 30, 2011, as required by the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432). The rule also codified changes to the permissible class of health care items or services related to managed care organizations as enacted by the Deficit Reduction Act of 2005 (Pub. L. 109–171).

The February 22, 2008 final rule became effective on April 22, 2008. However, section 7001(a)(3)(C) of the Supplemental Appropriations Act of 2008, Pub. L. No. 110–252, imposed a partial moratorium until April 1, 2009, prohibiting CMS from taking any action to implement any provisions of the final rule that are more restrictive than the provisions in effect on February 21, 2008, with the exception of the change in the statutory definition of the class of services of a managed care organization and the statutorily-required change to the indirect guarantee threshold test. This moratorium was extended by

section 5003(a) of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Public Law 111–5, until July 1, 2009. Although not subject to the moratorium, a statutorily established transition period was established until October 1, 2009, for those States with previously enacted health care-related taxes under the previous definition of Medicaid managed care organization services.

On May 6, 2009, we published a proposed rule (74 FR 21230) that delayed the enforcement of the changes made in the February 22, 2008 final rule to the hold harmless tests under § 433.54(c) and § 433.68(f), other than the statutorily-required change to the indirect guarantee threshold level, until June 30, 2010. This portion of the regulation has been the subject of the Congressional moratoria and has not yet been implemented by CMS. We explained that the delay was necessary in order to determine whether additional clarification or guidance is necessary or helpful to our State partners. In addition, we explained that certain States were concerned that the regulatory language is broad or unclear. Furthermore, we indicated that the delay would allow more time to obtain information about the potential impact of the rule and alternative approaches, and to ensure appropriate implementation of the statutory restrictions on provider taxes and donations.

II. Provisions of the Proposed Rule and Response to Comments

In the May 6, 2009 proposed rule (74 FR 21230), we proposed to delay enforcement of certain provisions concerning hold harmless arrangements, for 1 year. We received a total of 11 timely comments from national hospital associations, State Medicaid Agencies, and the National Association of State Medicaid Directors. The comments supported our decision to delay enforcement of certain clarifications regarding standards for determining hold harmless arrangements in the final rule entitled, “Medicaid Program; Health Care-Related Taxes” from the expiration of a Congressional moratorium on enforcement on July 1, 2009 to June 30, 2010. We appreciate these comments and agree that the delay in enforcement of these specific provisions is merited. A summary of the public comments we received, and our responses to comments, are set forth below.

Comment: Several commenters expressed support for CMS in delaying enforcement of clarifications regarding standards for determining hold harmless

arrangements. Commenters indicated that this delay would enable the Agency to further examine the impact of changes on States and providers. The commenters felt that any change to current policy should be carefully considered to ensure that it would not negatively affect the ability of State Medicaid programs to maintain coverage and payment levels. Some commenters believe that the provisions of the rule relating to the hold harmless provision overstepped the authority and guidelines provided by Congress. Commenters encouraged CMS to work with States to develop objective standards by which the hold harmless provisions for health care-related taxes can be measured.

Response: We appreciate the commenters’ support for the delay in enforcement of the clarifications regarding standards for determining hold harmless arrangements. We will continue to work with States to ensure that Federal statutory requirements are met. We are committed not only to applying objective analysis in determining whether State tax programs contain hold harmless arrangements but also to working with each State on a case-by-case basis, given the unique nature of the programs, to ensure implementation of permissible tax programs.

As indicated by the commenters, the delay will provide us with time to determine whether further clarification or guidance is needed and would be of assistance to States. The delay will also allow more time to obtain information about the potential impacts of the rule and alternative approaches as well as to assure the appropriate implementation of the statutory restrictions.

Comment: Several commenters stated that the current provisions of the hold harmless test specified in the March 23, 2007 (72 FR 13726) proposed rule do not represent a reasonable interpretation of Federal statutory guidelines. Commenters believe that the hold harmless clarifications should be rescinded in their entirety and returned to the original regulatory language from the August 13, 1993 (58 FR 43156) final rule. These commenters stated that the 1993 regulatory language represented clearly understood and easily interpreted standards.

Response: Our responsibility is to ensure that the Federal statutory requirements governing health care-related taxes are met. Therefore, we believe it is necessary and appropriate for the Secretary to issue regulatory provisions to provide States with clear guidance on which health care-related tax programs are permissible and

therefore eligible for Federal Financial Participation (FFP). We understand that certain States are concerned that the current regulatory language may be overly broad or unclear. During the delay in enforcement, we will work with States to learn more about the potential impact of the current regulatory language and to explore other alternatives in order to assure the appropriate implementation of the statutory restrictions.

Comment: One commenter resubmitted their original comments to the March 23, 2007 proposed rule.

Response: Comments on the March 23, 2007 proposed rule were previously considered and responded to in the February 22, 2008 final rule; therefore, we are not responding to them in this rule.

III. Provisions of the Final Regulations

In this final rule, we are adopting the provisions as set forth in the May 6, 2009 proposed rule (74 FR 21232) as final, with no changes.

IV. Waiver of Delay in Effective Date

We ordinarily provide a 30-day delay in the effective date of the provisions of a notice in accordance with section 553(d) of the Administrative Procedures Act (APA), at 5 U.S.C. 553(d). We can waive the 30-day delay in effective date, however, if the Secretary finds, for good cause, that it is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons in the notice.

We find there is good cause to waive the delay in the effective date of this issuance because we find that, since the hold harmless provisions of the rule for which enforcement will be delayed have been subject to Congressional moratoria and are not currently being implemented, it would be contrary to the public interest to implement them briefly and then change them back. Such sudden, short-term changes would result in public confusion and administrative chaos. Therefore, under 5 U.S.C. 553(b)(3)(B), for good cause, we waive notice and comment procedures.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VI. Regulatory Impact Analysis

A. Overall Impact

We have examined the impact of this final rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993, as further amended), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of all available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year).

The final rule on health care-related taxes was estimated to result in savings to the Federal government, by reducing its financial participation in the Medicaid program for amounts in excess of the tax-related threshold, with corresponding responses by States that would partially offset these savings. Specifically, the RIA for the final rule estimated that Federal Medicaid outlays would be reduced by \$85 million in FY 2008, and \$115 million per year in FY 2009 through FY 2011. These savings resulted directly from applying the language in the Tax Relief and Health Care Act of 2006 to reduce the maximum threshold on exclusion of health care-related taxes from 6 percent to 5.5 percent of net patient revenue. This final rule does not delay application of this reduced threshold, which is already in effect. This final rule delays the provisions governing the determination of whether health care provider taxes or donations constitute “hold harmless” arrangements. Accordingly, we believe that the delay would not have any substantial economic effect, and that this final rule is not “economically significant” under E.O. 12866 or “major” under the Congressional Review Act.

The RFA requires agencies to analyze options for regulatory relief of small entities if proposed or final rules have a “significant economic impact on a substantial number of small entities.” For purposes of the RFA, small entities include small businesses, nonprofit

organizations, and small governmental jurisdictions, including school districts. “Small” governmental jurisdictions are defined as having a population of less than fifty thousand. Individuals and States are not included in the definition of a small entity. In the final rule on health care-related taxes, we analyzed potential impacts on small entities that might result from the change in the exclusion threshold. Some effects (such as reduced tax burden) were likely to be positive, and some (such as reductions in State reimbursement rates) could be either positive or negative. All of these effects would depend on future State decisions on taxation and reimbursement that could not be predicted and would in any event be indirect effects rather than the direct result of that rule. Regardless, this rule does not propose to delay the change in the exclusion threshold. As a result, the Secretary has determined that this final rule would not have a significant effect on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis, if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. Our analysis of the final rule concluded that it would have had no significant direct effect on a substantial number of these hospitals. This final rule does not impose any new requirements. Accordingly, we are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this final rule would not have a direct impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. In 2009, that threshold level is currently approximately \$133 million. This final rule contains no mandates that will impose spending costs on State, local, or tribal governments in the aggregate, or by the private sector, of \$133 million.

Executive Order 13132 on Federalism establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirements on State and local

governments, preempts State law, or otherwise has Federalism implications. EO 13132 focuses on the roles and responsibilities of different levels of government, and requires Federal deference to State policy-making discretion when States make decisions about the uses of their own funds or otherwise make State-level decisions. The original final rule, while limiting Federal funding, did not circumscribe the States’ authority to make policy decisions regarding taxes and reimbursement. This final rule will likewise not have a substantial effect on State or local government policy discretion.

B. Anticipated Effects

As discussed in the February 22, 2008 final rule, States had a number of options open to them in addressing any reduction in Federal Financial Participation (FFP). They could restructure State spending and shift funds among programs, raise funds through increases in other forms of generally applicable tax revenue increases, or reduce reimbursement to the tax-paying health care providers. Presumably, most of those States have already made those decisions. The delay in this final rule will not affect the tax threshold; it will provide some relief to States in making other adjustments.

C. Alternatives Considered

In the May 6, 2009 proposed rule, we welcomed comments not only on the delay in enforcement, but also on alternatives that may more constructively address the underlying problems and their likely impacts on States and other stakeholders. Some commenters recommended that CMS rescind rather than delay the enforcement of the hold harmless provisions. There were no other specific alternatives offered by commenters. Commenters reiterated that we should work with States to develop objective standards by which compliance with the hold harmless provisions can be measured. CMS will take these comments into consideration throughout the enforcement delay period to assure the most appropriate implementation of the statutory provisions.

The only other option considered was to not finalize this delay in enforcement. However, as discussed in the preamble to this final rule and the response to comments, we believe that this is not the best alternative at this time.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: June 5, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: June 17, 2009.

Kathleen Sebelius,

Secretary.

[FR Doc. E9-15347 Filed 6-29-09; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 071130780-8013-02]

RIN 0648-XQ05

Magnuson-Stevens Fishery Conservation and Management Act Provisions; Fisheries of the Northeastern United States; Atlantic Sea Scallop Fishery; Closure of the Closed Area II Scallop Access Area to Scallop Vessels

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Temporary rule; closure.

SUMMARY: NMFS announces the closure of Closed Area II Scallop Access Area (CA II) to scallop vessels until June 15, 2010. This closure is based on a determination by the Northeast Regional Administrator (RA) that scallop vessels will have caught the yellowtail flounder (yellowtail) total allowable catch (TAC) for the CA II by June 29, 2009. Effective 0001 hours, June 29, 2009, vessels may not fish for scallops in the CA II. Vessels on a CA II scallop trip at the time of this announcement must leave the CA II prior to 0001 hour, June 29, 2009. This action is being taken to prevent the scallop fleet from exceeding the yellowtail TAC allocated to the CA II for the 2009 scallop fishing year in accordance with the regulations implementing the Atlantic Sea Scallop Fishery Management Plan (FMP), Northeast (NE) Multispecies FMP and the Magnuson-Stevens Fishery Conservation and Management Act.

DATES: The closure of the CA II to all scallop vessels is effective 0001 hr local time, June 29, 2009, until June 15, 2010.

FOR FURTHER INFORMATION CONTACT: Don Frei, Fishery Management Specialist, (978) 281-9326, fax (978) 281-9135.

SUPPLEMENTARY INFORMATION:

Commercial scallop vessels fishing in access areas are allocated 9.8 percent of the annual yellowtail TACs established in the (NE) Multispecies FMP. Given current fishing effort by scallop vessels in the CA II, the RA has made a determination that the CA II yellowtail TAC of 349,358 lb (148.47 mt) is projected to be caught on June 29, 2009. Pursuant to 50 CFR 648.60(a)(5)(ii)(C) and 648.85(c)(3)(ii), this **Federal Register** notice notifies scallop vessel owners that, effective 0001 hours on June 29, 2009, federally permitted scallop vessels are prohibited from declaring or initiating a trip into the CA II until June 15, 2010.

If a vessel with a limited access scallop permit has an unused trip(s) into CA II, it will be allocated 7.9 additional open areas days-at-sea (DAS) for each unused trip. If a vessel has been allocated a broken trip compensation trip that cannot be made, it will be allocated prorated open area DAS based on the remaining allocation and the above listed access area DAS conversion rate. For example, if a full-time vessel had an unused 9,000-lb CA II compensation trip (half of the full possession limit) at the time of a CA II yellowtail TAC closure, the vessel will be allocated 3.95 DAS (half of the 7.9 DAS that would be allocated for a full CA II trip). A separate letter will be sent to notify vessel owners of their allocations for unused trips in the CA II.

Classification

This action is required by 50 CFR part 648 and is exempt from review under Executive Order 12866.

Due to the need to take immediate action to close the CA II once the yellowtail TAC has been taken, pursuant to 5 U.S.C. 553(b)(3) proposed rulemaking is waived because it would be impracticable and contrary to the public interest to allow a period for public comment. The CA II opened for the 2009 fishing year on June 15, 2009. Data indicating the scallop fleet has taken, or is projected to take, all of the CA II yellowtail TAC have only recently become available. To allow scallop vessels to continue to take trips in the CA II during the period necessary to publish and receive comments on a proposed rule would result in vessels taking more yellowtail than allocated to the scallop fleet. Excessive yellowtail harvest from CA II would result in excessive fishing effort on the Georges Bank yellowtail stock, where tight effort controls are critical for the rebuilding program. Should excessive fishing effort occur, future management measures may need to be more restrictive. Based

on the above, under 5 U.S.C. 553(d)(3), proposed rule making is waived because it would be impracticable and contrary to the public interest to allow a period for public comment. Furthermore, for the same reasons, there is good cause under 5 U.S.C. 553(d)(3) to waive the 30-day delayed effectiveness period for this action.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: June 25, 2009

Alan D. Risenhoover,

Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. E9-15432 Filed 6-25-09; 4:15 pm]

BILLING CODE 3510-22-S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 090421699-91029-02]

RIN 0648-XO74

Fisheries Off West Coast States; Coastal Pelagic Species Fisheries; Annual Specifications Modification

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: NMFS issues this final rule to adjust the harvest specifications for Pacific sardine in the U.S. exclusive economic zone (EEZ) off the Pacific coast for the fishing season of January 1, 2009, through December 31, 2009. This final rule increases the tonnage of Pacific sardine allocated for industry conducted research from 1200 metric tons (mt) to 2400 mt and decreases the second and third period directed harvest allocations by 750 mt and 450 mt, respectively.

DATES: Effective July 1 through December 31, 2009.

FOR FURTHER INFORMATION CONTACT: Joshua Lindsay, Southwest Region, NMFS, (562) 980-4034.

SUPPLEMENTARY INFORMATION: On February 20, 2009, NMFS published a final rule implementing the harvest guideline (HG) and annual specifications for the 2009 Pacific sardine fishing season off the U.S. West Coast (74 FR 7826) under the Magnuson-Stevens Fishery Conservation and Management Act, 16 U.S.C. 1801 *et seq.* (Magnuson-Stevens Act). These specifications and associated management measures were

4302. **OPTIONAL TARGETED CASE MANAGEMENT SERVICES - BASIS, SCOPE AND PURPOSE**

The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272, COBRA) added §§1915(g)(1) and (g)(2) to the Act. These sections add optional targeted case management services to the list of services that may be provided under Medicaid. Section 1895(c)(3) of the Tax Reform Act of 1986 (P.L. 99-514) added case management services to the list of services in §1905 of the Act. Section 4118(i) of OBRA 1987 (P.L. 100-203) added a section discussing the qualifications of case managers for individuals with developmental disabilities or chronic mental illness. Both the Tax Reform Act and OBRA 1987 amendments are effective as if included in COBRA and are considered effective on April 7, 1986.

A. Background.--Case management is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. Prior to the enactment of P.L. 99-272, States could not provide case management as a distinct service under Medicaid without the use of waiver authority. However, aspects of case management have been an integral part of the Medicaid program since its inception. The law has always required interagency agreements under which Medicaid patients may be assisted in locating and receiving services they need when these services are provided by others. Prior to the enactment of P.L. 99-272, Federal financial participation (FFP) for case management activities may be claimed in any of four basic areas:

1. Component of Another Service.--Case management may be provided as an integral and inseparable part of another covered Medicaid service. An example of this type of case management is the preparation of treatment plans by home health agencies. Since plan preparation is required as a part of home health services, separate payment for the case management component cannot be made, but is included in the payment made for the service at the Federal Medical Assistance Percentage (FMAP) rate.

2. Administration.--Case management may be provided as a function necessary for the proper and efficient operation of the Medicaid State plan, as provided in §1903(a) of the Act. Activities such as utilization review, prior authorization and nursing home preadmission screening may be paid as an administrative expense. The payment rate is either the 50 percent matching rate or the 75 percent FFP rate for skilled professional medical personnel, when the criteria in 42 CFR 432.50 are met.

3. Section 1915(b) Waivers.--Case management may be provided in a waiver granted under §1915(b) of the Act. Section 1915(b) provides that a State may request that the Secretary waive the requirements of §1902 of the Act, including the freedom of choice requirements in §1902(a)(23), if necessary to implement a primary care case management system as described in 42 CFR 431.55(c).

To qualify for such a waiver, the case management project must be cost effective, efficient, and consistent with the objectives of the Medicaid program. The waiver is needed to restrict the provider from (or through) whom an eligible individual can obtain medical care services (other than in emergency circumstances), provided the restriction does not substantially impair access to services of adequate quality, and that the statutory and regulatory requirements for waiver approvals are met. Upon the written request of the State, case management services furnished on or after April 7, 1986 pursuant to a waiver granted under §1915(b)(1) may be reimbursed at the FMAP rate when these services are performed by a vendor. Because of the nature of case management services under a §1915(b)(1) waiver, this activity, when performed by an employee of the Medicaid agency, is construed as necessary for the proper and efficient administration of the State plan and is therefore an administrative expense.

4. Section 1915(c) Waivers.--Case management may be provided as a service in a waiver granted pursuant to §1915(c) of the Act. Section 1915(c)(4)(B) specifically enumerates case management as a service which may be provided as part of a home and community-based services waiver. In order to provide this service, you must define it as part of a waiver request, and identify the qualifications of the providers. Under such a waiver, case management services must be provided under a written plan of care which is subject to the approval of the State Medicaid agency. Services provided in this fashion are reimbursed at the FMAP rate. Section 4440 supplies additional information concerning home and community-based services waivers.

NOTE: The enactment of P.L. 99-272 and P.L. 99-514 has not altered your authority to provide any of the previous categories of case management.

B. Legislation.--P.L. 99-272 adds case management to the list of optional services which may be provided under Medicaid. Section 9508 of P.L. 99-272 adds a new subsection (g) to §1915 of the Act. This subsection, as amended by P.L. 100-203, provides that:

"(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS); or with AIDS-related conditions, or with either, and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection, 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.”

In authorizing States to offer case management services, Congress recognized that there was some potential for duplicate payments because the same or similar services have often been provided by other programs or under the Medicaid program itself. H. Rep. No. 453, 99th Cong., 1st Session 546 (1985), which accompanies this portion of P.L. 99-272, emphasizes that payment for case management services under §1915(g) must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

FFP is available at the FMAP rate for targeted case management services rendered on or after April 7, 1986, when these services are included in the State plan.

C. Technical Statutory Change.--Section 1895(c)(3) of the Tax Reform Act of 1986 adds case management services to §1905(a)(19) of the Act. In so doing, it defines §1905(a)(19) in terms of §1915(g)(2).

D. Purpose.--The purpose of these instructions is to implement these sections of the statute, and to provide clarification regarding the requirements of the statute and how they may be met.

4302.1 Case Management Services - Process.--

A. Applicability.--The process described in this section applies to case management services, as described in §1905(a)(19) and §1915(g) of the Act.

B. Submission and Timeframes.--Case management under either §1905(a)(19) or §1915(g) is an optional service under Medicaid. To provide the service, incorporate it into your Medicaid State Plan by means of a State plan amendment submitted to your servicing regional office. As with all State plan amendments that provide additional services, the effective date may be no earlier than the first day of the calendar quarter in which the amendment is submitted. In no case may FFP be claimed for case management services under §1915(g) provided prior to April 7, 1986.

In order to provide services under §1915(g), submit a separate amendment for each target group. There is no limit to the number or size of target groups to whom you may provide case management services. The target group may be the State’s entire Medicaid population.

4302.2 State Plan Amendment Requirements.--Any State plan amendment request to provide optional case management services must address all of the requirements of this section.

A. Target Group--Identify the target group to whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition (e.g., Acquired Immune Deficiency Syndrome (AIDS) or Chronic Mental Illness), or any other identifiable characteristic or combination thereof. The following examples are target groups currently receiving case management services under §1915(g) of the Act:

- o Developmentally disabled persons (as defined by the State);
- o Children between the ages of birth and up to age 3 who are experiencing developmental delays or disorder behaviors as measured and verified by diagnostic instruments and procedures;
- o Pregnant women and infants up to age 1;
- o Individuals with hemophilia;
- o Individuals 60 years of age or older who have two or more physical or mental diagnoses which result in a need for two or more services; and
- o Individuals with AIDS or HIV related disorders.

In defining the target group, you must be specific and delineate all characteristics of the population.

B. Comparability--Unless you intend to provide case management services in the same amount, duration and scope to all eligible recipients, indicate that §1915(g)(1) of the Act is invoked to provide these services without regard to the requirements of §1902(a)(10)(B) of the Act. (See 42 CFR 440.240.) The exception to comparability requirements applies only to case management services under §1915(g) of the Act. Comparability requirements relating to all other Medicaid services are unaffected by this section.

C. Statewide Availability--Indicate whether case management services are available to the target group statewide or whether the authority of §1915(g)(1) of the Act is invoked to provide case management services to the target group on a less than statewide basis. If case management services are not to be provided on a statewide basis, indicate the geographic areas or political subdivisions to be served. The provision of targeted case management services on a less than statewide basis does not excuse you from the requirements of §1902(a)(1) of the Act (see 42 CFR 431.50) in regard to the statewide availability of other Medicaid services.

D. Freedom of Choice--Section 1915(g)(1) of the Act specifies that there shall be no restriction on free choice of qualified providers, in violation of §1902(a)(23) of the Act. Assure that there will be no restriction on a recipient's free choice of qualified providers of case management services. In addition, assure that case management services will not restrict an individual's free choice of providers of other Medicaid services.

In order to meet the freedom of choice requirements, you must provide for the following:

1. Option to Receive Services.--The receipt of case management services must be at the option of the individual included in the target population. A recipient cannot be forced to receive case management services for which he or she might be eligible.

2. Free Choice of Providers.--Except as indicated for individuals with developmental disabilities or chronic mental illness, an eligible individual must be free to receive case management services from any qualified provider of these services. The recipient may not be limited to case management providers in a clinic, even if the individual receives all other Medicaid services through that clinic. However, in situations where the State has chosen to provide case management services on a less than statewide basis, free choice of the qualified providers is limited to those providers located within all of the identified geographic areas or political subdivisions, as specified in the State plan.

When providing case management services to individuals with developmental disabilities or with chronic mental illness, you may limit the case managers available. This ensures that the case managers for these individuals are capable of providing the full range of needed services to these targeted recipients. This limitation is permissible only with regard to the target groups of developmentally disabled or chronically mentally ill, or any subgroups that you choose to define. If you choose to target a subgroup of individuals who are developmentally disabled or chronically mentally ill, the targeted group (e.g., based on age, degree of impairment) must continue to fit the definition of chronic mental illness or developmental disability. The requirements discussed in items D.1, D.3, and D.4 continue to apply to all target groups.

3. Provider Participation.--Any person or entity meeting State standards for the provision of case management services who wishes to become a Medicaid provider of those services must be given the opportunity to do so. However, the State is not required to extend provider participation to providers located outside the geographic areas in which case management is targeted.

4. Unrestricted Access.--Case management services under §1915(g) of the Act may not be used to restrict the access of the client to other services available under the State plan. This option is, however, available through waivers granted pursuant to §1915(b) of the Act. (See §2100.)

E. Qualifications of Providers.--The statute does not set minimum standards for the provision of case management services. Therefore, establish the minimum qualifications for the providers of case management services. The qualifications set must be reasonably related to the case management functions that a provider is expected to perform. While reasonable provider qualifications are necessary to assure that case managers are capable of rendering services of acceptable quality, use caution in determining the acceptable degree of such qualifications. With the exception of providers of case management services to individuals with developmental disabilities or chronic mental illness, provider qualifications must not restrict the potential providers of case management services to only those viewed as most qualified. Individuals within the specified target group must be free to receive case management services from any qualified provider.

Except as discussed in item D.2, you may not limit the provision of these services to State or other public agencies, but must permit any person or entity that meets the established qualifications in accordance with 42 CFR 431.51(b) to become a Medicaid provider.

F. Nonduplication of Payments.--Payment for case management services under §1915(g) of the Act may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

In general, payment may not be made for services for which another payer is liable. Exceptions to this general rule include payments for prenatal or preventive pediatric care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services; payments for services covered under a plan for an individual for whom child support enforcement is being carried out; or any payments made through a waiver granted under the cost effectiveness provisions of 42 CFR 433.139(e). Another major exception is that payments may be made to State education agencies to cover the costs of services provided under a recipient's Individualized Education Program.

Payment may not be made for services for which no payment liability is incurred. Similarly, separate payment cannot be made for similar services which are an integral and inseparable part of another Medicaid covered service.

G. Differentiation Between Targeted Case Management Services and Case Management Type Activities for Which Administrative Federal Match May Be Claimed.--You must differentiate between case management services which may properly be claimed at the service match under §1915(g) and case management activities which are appropriate for FFP at the administrative match under the State plan, based upon the appropriate criteria. These two payment authorities do not result in mutually exclusive types of services.

There are certain case management activities which may appropriately be eligible for FFP at either the administrative or the service match rate. Examples of case management activities that may be claimed at either the administrative or the service match rate entail providing assistance to individuals to gain access to services listed in the State plan, including medical care and transportation. In cases where an activity may qualify as either a Medicaid service or an administrative activity, you may classify the function in either category. This decision must be made prior to claiming FFP because of the different rules which apply to each type of function under the Medicaid program.

1. Case Management as a Service Under §1915(g).--FFP is available at the FMAP rate for allowable case management services under §1915(g) when the following requirements are met:

o Expenditures are made on behalf of eligible recipients included in the target group (i.e. there must be an identifiable charge related to an identifiable service provided to a recipient);

o Case management services are provided as they are defined in the approved State plan;

o Case management services are furnished by individuals or entities with whom the Medicaid agency has in effect a provider agreement;

o Case management services are furnished to assist an individual in gaining or coordinating access to needed services; and

o Payment for services is made following the receipt of a valid provider claim. Providers must maintain case records which indicate all contacts with and on behalf of recipients. The case records must document name of recipient, the date of service, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service delivery. In addition, providers must develop a billing system to appropriately identify and bill all liable third parties.

Because §1915(g) of the Act defines case management services as services which assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services, recipients may obtain access to services not included in the Medicaid State plan. The costs of case management services provided under §1915(g) that involve gaining access to non-Medicaid services are eligible for FFP at the service match rate.

Examples of case management services provided under §1915(g) of the Act may include assistance in obtaining Food Stamps, energy assistance, emergency housing, or legal services. All case management services provided as medical assistance pursuant to §1915(g) of the Act must be described in the State plan. In addition, they must be provided by a qualified provider as defined in the State plan.

When case management is provided pursuant to §1915(g) of the Act, the service is subject to the rules pertaining to all Medicaid services. If you choose to cover targeted case management services under your State plan, as defined in §1915(g) of the Act, you cannot claim FFP at the administrative rate for the same types of services furnished to the same target group.

NOTE: Although FFP may be available for case management activities that identify the specific services needed by an individual, assist recipients in gaining access to these services, and monitor to assure that needed services are received, FFP is not available for the cost of these specific services unless they are separately reimbursable under Medicaid. Also, FFP is not available for the cost of the administration of the services or programs to which recipients are referred.

2. Case Management as an Administrative Activity.--Case management activities may be considered allowable administrative costs of the Medicaid program when the following requirements are met:

o They are provided in a manner consistent with simplicity of administration and the best interest of the recipient, as prescribed by §1902(a)(19) of the Act; and

o Documentation maintained in support of the claim is sufficiently detailed to permit HCFA to determine whether the activities are necessary for the proper and efficient administration of the State plan, as provided by §1903(a) of the Act.

REQUIREMENTS AND LIMITS
APPLICABLE TO SPECIFIC SERVICES

12-91

The following list of functions provides examples of activities which may properly be claimed as administrative case management activities, but not as targeted case management services. The omission of any particular function from this list does not represent a determination on HCFA's part that the function is not necessary for the administration of the plan.

- o Medicaid eligibility determinations and redeterminations;
- o Medicaid intake processing;
- o Medicaid preadmission screening for inpatient care;
- o Prior authorization for Medicaid services and utilization review; and
- o Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system).

Because activities related to services which Medicaid does not cover are not considered necessary for the administration of the Medicaid plan, the accompanying costs are not eligible for Medicaid FFP at the administrative rate. For example, case management related to obtaining social services, Food Stamps, energy assistance, or housing cannot be considered a legitimate Medicaid administrative expense even though it may produce results which are in the best interest of the recipient. These services can be provided as medical assistance if described in the State plan.

Similarly, setting up an appointment with a Medicaid participating physician and arranging for transportation for a recipient may be considered case management administrative activities necessary for the proper and efficient administration of the Medicaid plan. However, arranging for baby sitting for a recipient's child, although beneficial to the recipient, is not an activity for which administrative FFP can be claimed.

In addition, when a caseworker suspects that physical abuse of a recipient has occurred, the referral to medical care could be considered a reimbursable administrative activity under the Medicaid program. However, assisting the victim in obtaining emergency housing and legal services, although in the best interest of the recipient, is not an activity for which administrative FFP may be claimed. In cases where workers perform activities funded under multiple auspices, careful records must be kept to document the State's claims for Federal funds under the appropriate authorities.

Administrative case management activities may be performed by an entity other than the single State agency. However, there must be an interagency agreement in effect.

When a State expects to claim FFP for Medicaid administrative case management activities, the costs for these activities must be included in a cost allocation plan submitted to and approved by your HCFA RO. HCFA reserves the right to evaluate the activities for which FFP is claimed to determine whether they meet the requirements (either administrative or service match) for payment. When FFP is claimed for any functions performed as case management administrative activities under §1903(a) of the Act, documentation must clearly demonstrate that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan.

H. Case Management Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.--Care coordination, including aspects of case management, has always been an integral component of the EPSDT program, as described in 42 CFR 441.61. OBRA 1989 (P.L. 101-239) modified the EPSDT program by adding §1905(r) to the Act. Section 1905(r) requires that States provide any services included in §1905(a) of the Act, when medical necessity for the service is shown by an EPSDT screen, whether such services are covered under the State plan. While case management is required under the expanded EPSDT program when the need for the activity is found medically necessary, this does not mean §1915(g) targeted case management services. Therefore, when the need for case management activities is found to be medically necessary, the State has several options to pursue:

1. Component of an Existing Service.--Case management services may be provided to persons participating in the EPSDT program by an existing service provider such as a physician or clinic referring the child to a specialist.
2. Administration.--Case management services may be provided to EPSDT participants by the Medicaid agency or another State agency such as title V, the Health Department or an entity with which the Medicaid agency has an interagency agreement. Administrative case management activities must be found necessary for the proper and efficient administration of the State plan and therefore must be limited to those activities necessary for the proper and efficient administration of Medicaid covered services. FFP is available at the administrative rate.
3. Medical Assistance.--Case management services may be provided under the authority of §1905(a)(19) of the Act. The service must meet the statutory definition of case management services, as defined by §1915(g) of the Act. Therefore, FFP is available for assisting recipients in gaining access to both Medicaid and non-Medicaid services. FFP for case management services furnished under §1905(a)(19) of the Act is available at the FMAP rate.

Any combination of two or more of the above is possible, as long as FFP is not available for duplication of services.

I. Service Limitations.--The following are not allowable targeted case management services as defined in §1915(g)(2) of the Act.

1. Other Medicaid Services.--When assessing an individual's need for services includes a physical or psychological examination or evaluation, bill for the examination or evaluation under the appropriate medical service category. Referral for such services may be considered a component of case management services, but the actual provision of the service does not constitute case management.
2. Referral for Treatment.--When an assessment indicates the need for medical treatment, referral or arrangements for such treatment may be included as case management services, but the actual treatment may not be considered.
3. Institutional Discharge Planning.--Discharge planning is required as a condition for payment of hospital, NF and ICF/MR services. Therefore, this cannot be billed separately as a targeted case management service.

4. Client Outreach.--Outreach activities in which a State agency or a provider attempts to contact potential recipients of a service do not constitute case management services. The statute defines case management services as, "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services" (emphasis added). The attempt to contact individuals who may or may not be eligible for case management services does not fall under this definition. However, such outreach activities may be considered necessary for the proper and efficient administration of the Medicaid State plan. When this is the case, FFP is available at the administrative rate.

J. Coordination With Home and Community-Based Services Waivers.--Case management services continue to be available under home and community-based services waivers approved pursuant to §1915(c) of the Act. However, since approval for §1915(c) waiver services may only be granted for services not otherwise available under the State plan, the addition of case management services under the State plan may necessitate the modification of a home and community-based services waiver. In order to comply with the nonduplication of services requirements discussed in §4302B, the following elements apply to waivers under §1915(c).

1. Service Not Included in Waiver.--Home and community-based services waivers (and requests for waivers) which do not contain case management as a waiver service are not affected by this section.

2. Different Target Population.--Home and community-based services waivers (and requests for waivers) which are targeted at a population different from the group(s) to whom targeted case management services are provided are not affected by this section.

3. Duplication of State Plan Service.--When a home and community-based services waiver contains case management as a waiver service and the State adds case management services to the State plan, the following apply:

a. Same Target Population and Service Definition.--If the target population and the service definitions are the same, delete the case management services from the waiver through an amendment request, and make appropriate cost and utilization adjustments to the waiver cost effectiveness formula.

b. Same Service Definition.--If the definition of services is the same, but only a portion of waiver recipients (who receive waiver case management) are now eligible for the State plan service, the service may remain in the waiver. Adjustments must be made to the cost effectiveness formula to reflect the fact that a number of recipients now receive the State plan service.

4. Same Target Population.--If you have targeted case management services in your State plan for a particular group, and you submit a waiver request for the same targeted group, the request for waiver may not include case management services through the waiver under the same definition used in the State plan. If the case management is provided under an identical definition, it must be provided under the State plan and not under the waiver.

K. Payment Methodology.--The amendment must specify the methodology by which payments and rates are made. Indicate the payment methodology for public as well as private providers. Enter this information on attachment 4.19-B of the State plan.

L. Documentation of Claims for Case Management Services.--In order to receive payment for case management services under the plan (i.e., at the FMAP rate), fully document your claim as you do for any other Medicaid service. If you pay for case management services through capitation or prepaid health plans, the requirements of 42 CFR Part 434 must be met. With the exception of claims paid under capitation or prepaid health plan arrangements, you must document the following:

- o date of service,
- o name of recipient,
- o name of provider agency and person providing the service,
- o nature, extent, or units of service, and
- o place of service.

NOTE: While forms of documentation such as time studies, random moment sampling and cost allocation plans may be appropriate for claiming administrative FFP for activities in support of the State plan, these modes of documentation are not acceptable as a basis for Federal participation in the costs of Medicaid services. There must be an identifiable charge related to an identifiable service provided to a recipient.

4302.3 Instructions For Completing Preprint Supplement.--

A. State Plan Amendment.--To include case management services in your State plan, indicate your intentions on Attachment 3.1-A and 3.1-B of the State plan preprint. In addition, complete one preprint supplement for each target group to whom the services will be provided. (OMB approval is required under the Paper Work Reduction Act of 1980 and will be obtained.)

B. Supplement 1 to Attachment 3.1-A.--Exhibit 1 is a copy of supplement 1 to Attachment 3.1-A. Each item must be completed for the amendment to be approved.

Item 1. Define the target group. Indicate any limitations of disease or condition, age, institutional or noninstitutional status or other characteristic(s) by which the target group is identified.

Item 2. Check one category. If services are provided on a less than statewide basis, specify the geographic areas or political subdivisions to which the services will be provided.

Item 3. Check one category.

Item 4. Define case management services as they apply to the target population. Specify any limitations that apply. Indicate the unit(s) of service. Identify any coordination with non-Medicaid programs or agencies.

Item 5. Specify the qualifications of the providers. These qualifications must be reasonably related to the case management function(s) that the providers are expected to perform.

Item 6. No information necessary.

Item 7. No information necessary.

EXHIBIT I

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

CASE MANAGEMENT SERVICES

A. Target Group:

B. Areas of State in Which Services Will Be Provided:

Entire State

Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

Services are provided in accordance with §1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

D. Definition of Services:

E. Qualifications of Providers:

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

SMDL #01-013

January 19, 2001

Dear State Child Welfare and State Medicaid Director:

The Department of Health and Human Services (HHS) is dedicated to providing support to children and other populations who receive case management services. We want to take this opportunity to clarify HHS 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.

When social programs or other programs are also the providers of Medicaid case management services, a number of complex issues may arise. This letter clarifies existing HHS policy regarding State plan case management and Title IV-E foster care programs. Specifically, this letter discusses: (1) the Medicaid definition of case management services, (2) whether services provided to individuals not eligible for Medicaid, or eligible but not part of the target population, can be covered, and (3) application of third party liability rules.

Please note that we anticipate issuing additional guidance for State plan case management as it relates to all programs through notice and comment rulemaking in the future.

I. Definition of Case Management Services

Sections 1905(a)(19) and 1915(g)(2) of the Social Security Act (the Act) define case management as services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services are referred to as targeted case management (TCM) services when the services are not furnished in accordance with Medicaid statewideness or comparability requirements. This flexibility enables States to target case management services to specific classes of individuals and/or to individuals who reside in specified areas.

Because the statute permits states flexibility to target Medicaid case management services based on any characteristic or combination of characteristics, States may use eligibility for, or participation in, a state social welfare program or other programs as the basis for defining the target population among Medicaid eligible individuals. Foster care programs employ their own case workers who, in addition to facilitating the delivery of foster care benefits and services, help individuals access and coordinate the delivery of other services. When foster case workers are also enrolled in Medicaid as providers of case management services, States must undertake a careful review to ensure the activities to be claimed under Medicaid meet the definition of case management and are not directly connected to the delivery of foster care benefits and services.

While HCFA has not further defined case management services in regulations, activities commonly understood to be allowable include: (1) assessment of the eligible individual to determine service needs, (2) development of a specific care plan, (3) referral and related activities to help the individual obtain needed services, and (4) monitoring and follow-up. When consistent with Medicaid requirements discussed below, Medicaid can be used to supplement these activities for Medicaid eligible individuals when they are embedded in another social or other program. We discuss below activities that are allowable case management as well as activities that would be unallowable as case management. In general, allowable activities are those that include assistance in accessing a medical or other service, but do not include the direct delivery of the underlying service.

Assessment: This component includes activities that focus on needs identification. Activities include assessment of an eligible individual to determine the need for any medical, educational, social, and other services. Specific assessment activities include: taking client history, identifying the needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, and educators, if necessary, to form a complete assessment of the Medicaid eligible individual.

Care Planning: This component builds on the information collected through the assessment phase and includes activities such as ensuring the active participation of the Medicaid-eligible individual and working with the individual and others to develop goals and identify a course of action to respond to the assessed needs of the Medicaid eligible individual. The goals and actions in the care plan should address medical, social, educational, and other services needed by the Medicaid eligible individual.

Referral & Linkage: This component includes activities that help link Medicaid eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered case management.

Monitoring/Follow-up: This component includes activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the Medicaid eligible individual. The activities and contacts may be with the Medicaid eligible individual, family members, providers, or other entities. These may be as frequent as necessary to help determine such things as (i) whether services are being furnished in accordance with a Medicaid eligible individual's care plan, (ii) the adequacy of the services in the care plan, and (iii) changes in the needs or status of the Medicaid eligible individual. This function includes making necessary adjustments in the care plan and service arrangements with providers.

Unallowable services: 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, any 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. In the case of foster care programs, we view the following activities as part of the direct delivery of foster care services and therefore may not be billed to Medicaid as a case management activity. The following list is intended to be illustrative and not all inclusive: 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, and making placement arrangements. During the State plan approval process, HCFA will provide guidance to determine Medicaid billable activities.

II. Contacts with Non-eligible or Non-targeted Individuals

There is confusion involving contact with individuals who are not eligible for Medicaid or, in the case of targeted services, individuals who are Medicaid eligible but not part of the target population specified in the State plan. HCFA policy permits contacts with non-eligible or non-targeted individuals to be considered a Medicaid case management activity, and to be billed to Medicaid, when the purpose of the contact is directly related to the management of the eligible individual's care. It may be appropriate to have family members involved in all components related to the eligible individual's case management because they may be able to help identify needs and supports, assist the eligible individual to obtain services, provide case workers with useful feedback, and alert them to changes.

On the other hand, contacts with non-eligibles or 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. While the nature of the contacts may squarely fall into one of the components of case management (i.e., assessments, care planning, referral and follow-up), Medicaid cannot be used to pay for them due to the fact that the individual is not Medicaid eligible or is eligible but does not meet the targeting criteria set by a State in its State plan amendment.

III. Third Party Liability

In accordance with Medicaid third party liability policy, Medicaid would only be liable for the cost of these services if they fall within the definition of case management and there are no other third parties liable to pay.

The Administration for Children and Families has clarified that the Title IV-E program does not authorize reimbursement for the assessment, care planning, and monitoring of medical care and services. Since the Title IV-E program is not liable for the assessment, care planning, and monitoring of medical care needs, the cost for such activities could be billed to the State Medicaid program if the activities are furnished to a Medicaid eligible individual who is a member of a target group defined in the State plan. This also assumes that there is not another third party payer available to cover the costs of medical case management services provided to a Medicaid eligible individual.

In contrast, referrals to medical care providers are Title IV-E reimbursable. This means that referrals are not billable to Medicaid. Because Title IV-E is liable for covering case management for a range of other services (including referrals to medical care), States which offer Medicaid case management services to foster care populations must properly allocate case management costs between the two programs in accordance with OMB Circular A-87 under an approved cost allocation program.

If you have any questions, please contact Mary Jean Duckett, Director, Division of Benefits, Coverage and Payment, Disabled and Elderly Health Programs Group at 410-786-3294.

Sincerely,

/s/

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/s/

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