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FACT SHEET

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MEDICAID DEFINITION OF COVERED CASE MANAGEMENT SERVICES CLARIFIED

The Centers for Medicare & Medicaid Services (CMS) interim final rule with comment period (IFC) implementing section 6052 of the Deficit Reduction Act of 2005 (DRA) clarifies the Medicaid definition of covered case management and targeted case management (TCM) services. The rule includes measures to address concerns about improper billing of non-Medicaid services to the Medicaid program by some states, while also including significant beneficiary protections that ensure comprehensive and coordinated services to meet the needs of beneficiaries.

Case management consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. "Targeted" case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness.

Widespread improper billing by states of the Medicaid program for services mandated by other programs helped prompt Congress to address the problem in the DRA, which redefined the scope of allowable case management services, strengthened state accountability, and required that CMS issue regulations.

Many accounts of inappropriate Medicaid billing of TCM services have been documented by the Government Accountability Office (GAO). In one investigation of TCM claims, GAO found that inappropriate billing to Medicaid generated an estimated $12 million in extra federal funds to Georgia and $68 million in extra federal funds to Massachusetts from 2000-2004.

Across the nation, total spending for TCM services jumped by 76 percent between 1999 and 2003 from $1.7 billion to $3 billion. GAO officials believe that some of this increase can be linked to a growing trend among states to hire consultants to assist in administering their Medicaid programs. In some cases, states will pay these consultants a contingency fee based on their performance in maximizing federal Medicaid reimbursement.

The IFC proposes certain refinements and clarifications to Medicaid's case management benefit that are expected to save the program $1.2 billion over the next five years. At the same time, the rule ensures that Medicaid case management services include a comprehensive assessment and care plan that would not otherwise be available to beneficiaries.

Further, the IFC clarifies that case management services include assessment of an eligible individual; development of a specific care plan; referral to services; and monitoring and follow-up activities. The IFC specifies that direct services, such as transporting a beneficiary to an appointment or accompanying a beneficiary to a court appearance are not allowable under the definition of the Medicaid case management or TCM benefit.

MAJOR PROVISIONS IN THE FINAL RULE:

- **Defines case management**
    - the IFC reiterates the definitions of case management and targeted case management services contained in sections 1905(a)(19) and 1915(g) of the Social Security Act; and
    - the IFC ensures that case management services will be comprehensive and coordinated, and will include an assessment of an eligible individual; development of a specific care plan; referral to services; and monitoring and follow-up activities.

- **Specifies and provides examples of excluded activities**. The IFC excludes from the definition of case management services, activities that:
    - are an integral component of another Medicaid service;
    - include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
    - constitute the administration of foster care programs;
    - constitute the administration of another non-medical program such as guardianship, child welfare or child protective services, parole and probation functions, legal services, and special education (except case management included in an individualized education plan or individualized family services plan); and
    - are claimed as necessary for the administration of the State Medicaid Plan.

- **Defines the term "targeted case management services" as case management services that can be furnished to an individual, not necessarily to all persons eligible for TCM services**
    - states may "target" case management services to specific classes of individuals, or to individuals who reside in specified areas of the state.

- **Clarifies when a case manager's contacts with individuals who are not eligible for Medicaid, or who are not included in the target population, may**

qualify as Medicaid case management services

- contact with family members that are for the purpose of helping a Medicaid-eligible individual access services can be covered by Medicaid.

Section 6052 of the DRA was effective January 1, 2006. The public comment period will close 60 days from the date of publication in the *Federal Register*. The rule's provisions will be effective 90 days after publication.

To view the rule, visit http://www.cms.hhs.gov/MedicaidGenInfo/08_Medicaidregulations.asp