DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 21, 2018

Mr. Joshua Baker
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

RE: Title XIX State Plan Amendment, SC 12-001

Dear Mr. Baker:

We have reviewed the proposed State Plan Amendment, SC 12-001, which was submitted to the Atlanta Regional Office on April 20, 2012 with an effective date of January 1, 2013. This state plan was submitted in response to SC 11-005 companion letter which was issued on June 23, 2011. The purpose of this plan was to comply with 42 CFR 441.18(a)(8) which requires states to submit a separate SPA for each Targeted Case Management (TCM) group when the TCM services differ in terms of provider qualification, services, or methodology under which case management providers would be paid. Specifically this plan was re-titled as Individuals with Intellectual and Related Disabilities which was formally known as Non-Institutionalized Individuals with Mental Retardation and Related Disabilities.

Based on the information provided, the Medicaid State Plan Amendment SC 12-001 was approved on May 21, 2018. The effective date of this amendment is January 1, 2013. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Cheryl Wigfall at (803) 252-7299 or Maria Drake at (404) 562-3697.

Sincerely,

Davida Kimble
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 12-001

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441.18(8)(i) and 441.18(9)

7. FEDERAL BUDGET IMPACT:
a. FFY To be provided at a later date $
b. FFY $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 3.1-A, pages 1, 1.1, 1.2, 1.3, 1.4, 1.5
Attachment 4.19 B pages 6a, 6a.1, 6a.2, 6a.3, 6a.4, 6a.5, 6a.6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 1 to Attachment 3.1-A, page 1
Attachment 3.1-A Limitation Supplement, pages 7b, 8
Attachment 4.19B pages 6a, 6b, 6c, 6d, 6e, 6e.1, 6e.2, 6e.3, 6e.4, 6e.5

10. SUBJECT OF AMENDMENT:
Targeted Case Management Services for Individuals with Intellectual and Related Disabilities

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Keck was designated by the Governor to review and approve all state plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
April 20, 2012

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 04/20/12

18. DATE APPROVED: 05/21/18

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/13

20. SIGNATURE OF REGIONAL OFFICIAL:
Davida Kimble

21. TYPED NAME:
Davida Kimble

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS: Approved with following changes to block number 7a and 7b as authorized by the state on response dated 04/10/18.

Block # 7a change to read: FFY13 (512,622); 7b changed to read: FFY14 (684,854).

Physician Services

Reimbursement will be made to the hospice in accordance with the usual Medicaid reimbursement for physician services when these services are provided by hospice employees or physicians under agreement with the hospice. This reimbursement is in addition to the daily rate. Services furnished voluntarily by physicians are not reimbursable.

Consultant specialty services, when necessary for the palliative care and management of the terminal illness (e.g., radiation for pain relief), are covered separately and are reimbursed only to the elected hospice.

Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice, are not considered covered hospice services. These services are to be reimbursed directly to the provider physician. The hospice must notify the S. C. Department of Health & Human Services of the name of the physician who has been designated as the attending physician.

19. Targeted Case Management (TCM) services are provided to Medicaid eligible recipients determined to meet the criteria of the following: Individuals with Intellectual and Related Disabilities, At Risk Children, Adults with Serious and Persistent Mental Illness, At Risk Pregnant Women and Infants, Individuals with Psychoactive Substance Disorder, Individuals at Risk for Genetic Disorders, Individuals with Head and Spinal Cord Injuries and Similar Disabilities, Individuals with Sensory Impairments, and Adults with Functional Impairments. These criteria are located in Supplement 1 to Attachment 3.1-A.

The specific targeted case management services to be provided under this section of the state plan are as follows:

1) Comprehensive assessment and reassessment,
2) Development and revision of care plan,
3) Referral activities,
4) Monitoring and follow-up.

TCM for the above populations can be provided by governmental or private providers. In order to develop the Medicaid payment rate, the Medicaid Agency employed the following reimbursement methodology:

1. **Personnel Costs:**

Governmental Providers: We obtained, from the eight state agencies that provide targeted case management for their populations, the personnel classifications (from the South Carolina Office of Human Resources (SCOHR) Classifications Manual) of the case managers and their supervisors employed in their agency. We obtained from the South Carolina Office of Human Resources, effective July 2011, the compensation ranges, specifically the salary midpoint, for each classification title reported by these agencies as performing case manager or case management supervision services.

Private Providers: We obtained from the May 2010 ''OES State Occupational Employment and Wage Estimate'' classification titles (and average salaries) that were similar in description to those titles used by governmental providers for case managers.

The average salary data per classification title for the private provider's noted above along with the salary midrange per classification title for the governmental providers were averaged to obtain the base annual salary cost recognized in the determination of an hourly rate for TCM services.

1a Programmatic Supervision - The determination of the allowable programmatic supervision salary add-on is calculated as follows:

1) the annual salary midpoint for each classification title reported by the governmental providers as case management supervisors were averaged to obtain the base annual salary cost recognized for case management supervision,

2) the average annual salary cost per supervisor is multiplied by the estimated percentage of time case manager supervisors spend on programmatic supervision activities per supervised employee (i.e. allocable portion of annual salary for each case manager),

1b. The allocable portion of the annual average salary for the case manager supervisor is added to the average annual salary for the case manager to determine allowable TCM salary costs.

1c. Allowable annual TCM salary costs, as determined in 1b above, are multiplied by the fringe benefit rate for SC state government employees to determine total personnel costs associated with the TCM services.

2. **Other direct operating costs.** Other costs that can be directly assigned to the TCM service are added. These include:

2a. Supplies - Material and supply costs that are required for direct services to clients.

The overriding principle regarding this cost is that the materials or supplies are required or used by the direct (i.e. hands on) provider of service during the course of treatment or provision of care to the Medicaid recipient.

The following characteristics determine the charging of supplies to a medical service or case management:

a) commonly provided in the course of care/treatment by the practitioner or case manager without additional charge,
b) provided as incidental, but integral to the practitioners' or case managers' services, and
c) used by the "hands-on" medical provider or case manager.

2b. Travel/transportation costs - The travel expenses associated with state plan required visits to the client's home or client's place of residence as defined in the SCDHHS TCM Provider Manual.

3. Indirect costs - Indirect costs (those supporting costs that cannot be directly attributed to the service but rather apportioned over all benefitting programs/services) are recognized by the application of a 10% IDC rate as applied to personnel costs net of fringe benefits.

Determination of Targeted Case Management Rates:

The additional time required to travel to the homes of clients (or other place of residence) for face to face meetings reduces the productivity of the case worker and increases costs for travel. Therefore, two rates have been determined. One which recognizes the loss of productivity and the

increased cost related to travel when meeting the client and family in their home or other place of residence. The other reduced rate recognizes the increased level of productivity and reduced costs for case management services that are primarily rendered within the offices of the provider.

''Home/Residential Contact'' Case Management Rate:

The composition and determination of the ''Home/Residential Contact'' (as defined in the MTCM Provider Manual) CM rate is as follows:

a) personnel costs, salaries and fringe benefits, for the case manager and programmatic case manager supervisor as defined and developed in section 1 above,

b) direct supply costs as defined in section 2,

c) travel costs, (estimated annual mileage for required in home or place of residence visits X estimated unique client visits per year X Federal mileage rate),

d) indirect costs, the indirect cost rate applied as indicated in section 3 above.

The sum of the costs above represents the annual cost of ''Home/Residential Contact'' TCM services for one case manager. This result is divided by annual ''productive hours'' as determined by a productivity factor to determine an hourly TCM rate. The hourly rate is divided by four to produce a fifteen minute billing rate for ''Home/Residential Contact'' TCM services.

''Office Contact'' Case Management Rate

The composition and determination of the ''Office Contact'' (as defined in the MTCM Provider Manual) TCM rate is as follows:

e) personnel costs, salaries and fringe benefits, for the case manager and programmatic case manager supervisor as defined and developed in section 1 above,

f) direct supply costs as defined in section 2,

g) indirect costs, the indirect cost rate applied as indicated in section 3 above.

The sum of the costs above represents the annual cost of ''Office Contact'' TCM services for one case manager. This result is divided by annual ''productive hours'' as determined by a productivity factor to determine an hourly TCM rate. The hourly rate is divided by four to produce a fifteen minute billing rate for ''Office Contact'' TCM services.

Transition Rates

The rates above represent market based, industry wide rates reimbursable to both governmental and private providers of TCM services.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Targeted Case Management (TCM) services. The agency's fee schedule rate was set as of January 1, 2013 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov. However, for governmental providers of TCM services, a ''phase in'' period will be allowed to provide a transition from previous retrospective cost-based reimbursement to the market based rates. Reimbursement during the ''phase in'' period will be as follows:

1. Effective January 1, 2013 , the governmental provider will receive rates based on: 75% of their cost based rate from the SFY 2010 cost report (or their most recently filed cost report) and 25% of the market based rates (either ''Office Contact'' or ''Home/Residential Contact'') as determined by the methodologies described above.

2. Effective July 1, 2014, the governmental provider will receive rates based on: 50% of their cost based rate from the SFY 2010 cost report (or their most recently filed cost report) and 50% of the market based rates (either ''Office Contact'' or ''Home/Residential Contact'') as determined by the methodologies described above.

3. Effective July 1, 2015, the governmental provider will receive rates based on: 25% of their cost based rate from the SFY 2010 cost report (or their most recently filed cost report) and 75% of the market based rates (either ''Office Contact'' or ''Home/Residential Contact'') as determined by the methodologies described above.

4. Effective July 1, 2016, the governmental providers will be fully transitioned over to the market based rates, ''Office Contact'' or ''Home/Residential Contact'', as determined by the methodologies described above.

5. Private providers of TCM services will receive 100% of the market based rates as determined by the methodologies described above beginning January 1, 2013.

Annual Cost Identification Process for Governmental Providers:

Each governmental provider rendering Targeted Case Management services will be required to submit a CMS approved annual cost report to establish the costs of their services. Allowable costs will be classified as follows and reported separately for ''Office Contact'' and ''Home/Residential Contact'' TCM rates:

Direct Costs:

1) Personnel costs - Expenditures from the accounting records for the incurred salaries, payroll taxes, and fringe benefits for the employees providing case management services. For employees who are not assigned to work 100% of their time in TCM services, time sheets will be required to allocate salary, payroll taxes and fringe benefits.

   Only those personnel costs for individuals meeting the requirements of TCM Case Manager will be considered as allowable expenditures for the cost report and reconciliation.

2) Materials and supplies required for the provision of service.

The overriding principle regarding this cost is that the materials or supplies are required or used by the direct (i.e. hands on) provider of service during the course of treatment or provision of care to the Medicaid recipient.

The following characteristics determine the charging of supplies to a medical service or case management:

a) commonly provided in the course of care/treatment by the practitioner or case manager without additional charge,

b) provided as incidental, but integral to the practitioners' or case managers' services, and used by the "hands-on" medical provider or case manager.

3) Travel/transportation costs represent the travel expenses associated with visits to the client's home or place of residence for assessment(s) and monitoring.

The governmental providers of this service will report the actual travel/transportation cost incurred by case managers in the provision of case management services as identified through their accounting system. Examples of allowable expenditures include documented mileage paid to case managers for the use of their private vehicles and directly charged and documented expenses of the state providers' fleet vehicles used by case managers.

4) Any other direct costs not noted above but directly assignable, excluding subcontract arrangements for direct service delivery and costs included in indirect cost determination.

Supervision:

Costs of programmatic supervision will be added to the direct costs associated with the case managers. Allowability of supervisory costs is determined based on time and effort reports which will identify and separate administrative activities of the supervisor versus those activities that are programmatic in nature (i.e. participating in assessment and care plan meetings, participation in follow-up and re-evaluation activities, review and evaluation of case management documentation). Time and effort reports completed in accordance with 45 CFR Part 75 and 42 CFR Part 413 will be used to determine programmatic supervision costs.

Indirect Costs:

Allowable indirect costs can be determined in one of two ways:

- Allowable indirect costs can be determined by the application of the provider's federally approved indirect cost rate or federally approved cost allocation plan or

- An allocation of administrative/overhead costs as allowed in accordance with 45 CFR Part 75 and 42 CFR Part 413. This option will only be available for those state agencies that provide institutional or acute care services.

Total Allowable Costs of Targeted Case Management Services:

The allowable costs for targeted case management services will be the sum of allowable direct costs, programmatic supervisory costs as applicable, and indirect costs as determined above.

Service Statistics:

All governmental providers will be required to accumulate and report service utilization statistics (i.e. units of service) for the total universe of service recipients in keeping with the accumulation of costs by total population of users. The unit measure for this service for all providers, private and governmental, is fifteen (15) minutes.

Comparison of Allowable Medicaid Reimbursable Costs to Interim Payments:

The governmental providers of this service will submit a cost report within 120 days after the close of their fiscal year. Annual cost reports will be desk reviewed for accuracy and compliance with 45 CFR Part 75 and 42 CFR Part 413. The result of total allowable costs divided by total units of service produce the average allowable unit rate.

For governmental providers that use certified public expenditures as the source of state matching funds, the average allowable unit rate multiplied by Medicaid units of service (as determined by the SCDHHS MMIS) becomes annual allowable Medicaid cost for the governmental provider. This amount is compared to Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services. Any interim payments in excess of annual allowable Medicaid cost will be recouped from the governmental provider. Should interim payments fall below the annual allowable Medicaid cost no payment will be made to the provider.

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TARGETED CASE MANAGEMENT SERVICES

Individuals with Intellectual and Related Disabilities

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
South Carolina Medicaid eligible individuals with a suspected diagnosis of Intellectual Disability defined as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental phase, prior to age 22 years, OR a related disability as defined as a severe, chronic condition found to be closely related to retardation Intellectual Disability and meet the five following conditions:

1. It is manifested before 22 years of age for Intellectual Disability and related disabilities.
2. It is likely to continue indefinitely;
3. It results in substantial functional limitations in 3 or more of the following areas of major life activities: Self Care, Understanding and use of language, learning, mobility, self-direction, and capacity for independent living;
4. The person's needs are such that supervision is necessary due to impaired judgment, limited capabilities, behavior problems, abusiveness, assaultive behavior or because drug effects/medical monitoring; and
5. The person is in need of services directed toward acquiring skills to function as independently as possible or the prevention or regression or loss of current optimal functional status.

__X__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
__X__ Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
__X__ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive Assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;

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Individuals with Intellectual and Related Disabilities

- identifying the individual's needs and completing related documentation; and
- 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;
    - Assessments shall be conducted at least every 365 days, but may occur more frequently when significant changes occur or new needs are identified.
    - Development (and periodic revision as needed) of a specific care plan that is based on the information collected through the assessment that
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes 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 those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual;

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. The following monitoring requirements must be performed and documented in the record as follows:

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Individuals with Intellectual and Related Disabilities

- Face-to-Face with the eligible individual at least once every 180 days to ensure appropriateness of continued services; and at least one annual visit in the individual's natural environment to ensure appropriateness of services; and
- Face-to-face or telephone contact with eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness, utilization and continued need for services.

__X__ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
TCM Provider Qualifications

The provider agency/entity must have:

- An established system to coordinate services for Medicaid eligible individuals who may be covered under another program which offers components of case management or coordination similar to TCM (i.e., Managed Care, Child Welfare Services, as well as State waiver programs.);
- Demonstrated programmatic and administrative experience in providing comprehensive case management services and the ability and capability to differentiate Targeted Case Management services to be provided to the target group;
- Staff with case management qualifications;
- Established referral systems, demonstrated linkages, and referral ability with essential social and health service agencies;
- A minimum of three years providing comprehensive case management services to the target group;
- Demonstrated administrative capacity to ensure quality services in accordance with state and federal requirements;
- Complied with all State licensing and practice requirements, under Title 40 of the S.C. Code of Laws, that apply to the service;
- Demonstrated financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles;
- Established system to document and maintain individual case records in accordance with state and federal requirements;

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Individuals with Intellectual and Related Disabilities

- Demonstrated ability to meet state and federal requirements for documentation, billing and audits;
- Demonstrated ability to evaluate the effectiveness, accessibility, and quality of TCM services on a community-wide basis; and,
- Been recognized as a business or non-profit in good standing by local municipality or the State of South Carolina; and
- Ability to secure and store all records in-state or within 25 miles of the South Carolina Border.

The Targeted Case Manager Supervisor Qualifications:

- Possess a Bachelor's degree from an accredited college or university or possess licensure from the South Carolina Labor, Licensing and Regulation Board as a registered nurse and have two years of supervisory experience and two years of case management experience; and
- Be employed by the TCM Provider and not be on any State's or the Office of the Inspector General's Medicaid Exclusion List; and
- Be familiar with the resources for the service community.

The Targeted Case Manager must at a minimum:

1. Be employed by the TCM enrolled provider and not be on any State's or the Office of the Inspector General's Medicaid Exclusion List;
2. Possess baccalaureate or graduate degree from an accredited college or university or possess licensure from the South Carolina Labor, Licensing and Regulation Board as a registered nurse and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body;
3. Have the ability to access multi-disciplinary staff when needed;
4. Have documented experience, skills, or training in:
    a. Crisis Intervention;
    b. Effective Communication; and,
    c. Cultural diversity and competency.
5. Possess knowledge of community resources; and,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

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TARGETED CASE MANAGEMENT SERVICES

Individuals with Intellectual and Related Disabilities

2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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TARGETED CASE MANAGEMENT SERVICES

Individuals with Intellectual and Related Disabilities

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 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: 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; making placement arrangements. (42 CFR 441.18(c))

FFP only is available 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 except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Case management does not include:

- Activities to clients participating in any waiver program that includes case management services;
- Program activities of the agency itself that do not meet the definition of TCM;
- Diagnostic and/or treatment services;
- Restricting or limiting access to services, such as through prior authorization;
- Activities that are an essential part of Medicaid administration, such as outreach; intake processing, eligibility determination, or claims processing; and,
- Services that are an integral part of another service already reimbursed by Medicaid.