MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 16-10

Distribution: All Providers

Issued: May 4, 2016

Subject: Coverage of Targeted Case Management Services for Beneficiaries Who Were Served by the Flint Water System

Effective: May 9, 2016

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

The purpose of this policy is to describe the Targeted Case Management (TCM) services that are part of a comprehensive health benefit available to pregnant women and children who were served by the Flint water system during the specified time period who meet the Medicaid eligibility requirements (see bulletin MSA 16-11 for eligibility criteria and the 1115 Demonstration Waiver).

TCM services, in accordance with 42 CFR 440.169, assist individuals in gaining access to appropriate medical, educational, social, and/or other services. TCM services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow-up activities.

In addition to TCM services, eligible beneficiaries will receive the full array of Medicaid-covered benefits. This includes the provision of Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) for children up to age 21, Non-Emergency Medical Transportation (NEMT), and Maternal Infant Health Program (MIHP) services. **Implementation of this policy is contingent upon legislative appropriation and state plan approval from the Centers for Medicare & Medicaid Services (CMS).**

I. Eligibility

Eligibility for the TCM benefit is consistent with the Flint water group as defined in the Flint, Michigan Section 1115 Demonstration Waiver as approved by CMS.

Providers may verify beneficiary eligibility for TCM services through a Community Health Automated Medicaid Processing System (CHAMPS) online eligibility inquiry or via a Health Insurance Portability and Accountability Act (HIPAA) 270 transaction. The CHAMPS or 271 eligibility response for beneficiaries eligible for TCM services will show:

- A current MAGI category beginning with "**F**," and
- A current benefit plan of "**TCMF"** in addition to their assigned Medicaid or Children's Health Insurance Program (CHIP)-related benefit plans.

II. Core Elements of TCM

The purpose of TCM services is to provide a comprehensive array of case management services that are appropriate to the conditions of the individual. At a minimum, TCM services must include:

- A face-to-face comprehensive assessment, history, re-assessments, and identification of a course of action to determine the specific needs of the beneficiary and to develop an individual Plan of Care.
- Planning, linking, coordinating, follow-up, and monitoring to assist the beneficiary in gaining access to services.

- Coordination with the beneficiary's primary care provider (PCP), other providers, and Medicaid Health Plan (MHP), as applicable.
- Any other service approved by the department.

A. Initial/Annual Comprehensive Assessment Visit

All comprehensive assessment visits, including the initial face-to-face comprehensive assessment visit, should be conducted by a qualified licensed nurse or social worker with the beneficiary in the beneficiary's home or primary place of residence. The purpose of the comprehensive assessment visit is to gather sufficient information to develop an individualized Plan of Care for the beneficiary and to ensure that all other eligible individuals in the household are identified for further screening.

It is expected that face-to-face assessments are performed annually; however, the frequency should be based on the needs and circumstances of the individual and/or family. Active participation by the beneficiary and/or parent(s) or legal guardian(s) is necessary. Comprehensive assessment activities include:

- Obtaining client history;
- Identifying the beneficiary'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 beneficiary.

At a minimum, the comprehensive assessment visit shall assess:

- The growth and development of beneficiaries up to age 21;
- The behavioral profile of beneficiaries up to the age of 21 including the notation of aggressive or hyperactive behavior;
- The beneficiary's access to a PCP and other health care providers;
- Whether the beneficiary's PCP has conducted a developmental and social emotional screen(s) utilizing a standardized and validated tool such as the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE), or the Pediatric Symptom Checklist (PSC) as indicated by the American Academy of Pediatrics (AAP) Periodicity Schedule and documenting the results of any screenings performed;
- Whether the beneficiary's PCP has assessed the beneficiary for sources of toxic stress and for sources of strength using nationally recognized tools such as the Adverse Childhood Experiences (ACEs) and Resiliency questionnaires and documenting the results of any screenings performed;
- The beneficiary's access to pre-natal care, potential for pregnancy complications, pica activities, and intent to breastfeed (pregnant beneficiaries);
- The beneficiary's educational and nutritional needs including participation in the Women, Infants and Children (WIC) program and/or the Food Assistance Program (FAP);
- The beneficiary's environment and typical family practices that may pose a lead risk;
- Lead hazards within the family's dwelling; and
- Access to NEMT.

MDHHS may specify a required assessment instrument to be used by the case managers.

B. Development of the Plan of Care and Documentation

During or immediately following the face-to-face initial comprehensive assessment visit, a Plan of Care must be developed for beneficiaries who agree to participate in TCM services, with the active participation of the parent(s) or legal guardian(s) when applicable. The development (and periodic revision) of a specific Plan of Care that is based on the information collected through the comprehensive assessment must specify the goals and actions to address the medical, educational, social, and/or other services needed by the beneficiary. The case manager must ensure the active participation of the beneficiary, and work with the beneficiary (or the beneficiary's parent[s] or legal guardian[s]) and others to develop those goals, and to identify a course of action to respond to the assessed needs of the beneficiary. The Plan of

Care is to be shared with the beneficiary's MHP and PCP, if applicable. Beneficiaries must consent to share the Plan of Care with the MHP and other providers identified in the Plan of Care. At a minimum, the Plan of Care must:

- Identify a course of action to respond to the assessed needs of the beneficiary (e.g., plan for the testing of family members at risk for lead hazard exposure);
- Provide education and information regarding lead hazards, including the impact of lead exposure on the developing fetus of pregnant beneficiaries; and
- Facilitate blood lead testing and follow-up testing and treatment as recommended by the PCP.

TCM providers are required to document the following information for all beneficiaries receiving TCM services:

- The name of the beneficiary;
- The dates of the case management services;
- The name of the TCM provider and the qualified professional (i.e. licensed nurse or social worker) providing the case management services;
- The nature and content of the case management visits received, and whether goals specified in the Plan of Care have been achieved;
- Whether the beneficiary has declined services within the Plan of Care;
- The need for, and occurrences of, coordination with other providers;
- A timeline for obtaining needed services;
- A timeline for re-evaluation of the Plan of Care; and
- The beneficiary's consent to share information.

C. Referrals and Related Activities

In collaboration with the PCP and the MHP, it is expected that the case manager will facilitate and coordinate referral and related activities to assist the beneficiary in obtaining needed services. Activities, such as scheduling appointments or linking the beneficiary with medical, educational, social, and/or other programs and services to address identified needs and achieve goals specified in the Plan of Care are primary components of TCM services. Referral activities include, but are not limited to, the coordination of age appropriate services such as:

- Health care related services, including physical and specialty behavioral health services;
- Nutritional services such as coordinating referrals to the Special Supplemental Nutrition Program, WIC program or FAP;
- Educational services, such as age-appropriate referrals to Early On, Great Start Readiness Programs, Head Start, and school-based services;
- Additional social supports (including home visiting programs) to assist the beneficiary in obtaining other assistance, such as financial, housing, and transportation assistance, and lead assessment and abatement resources; and
- Blood lead testing and re-testing for family members at risk for lead exposure and education regarding lead hazards, including the impact of lead exposure on young children and the developing fetus.

D. Monitoring and Follow-Up Activities

Monitoring and follow-up activities include activities and contacts that are necessary to ensure the Plan of Care is implemented and adequately addresses the eligible beneficiary's needs, and which may be conducted with the beneficiary, family members, service providers, or other entities or individuals. Monitoring and follow-up activities are conducted as frequently as necessary by the case manager. A maximum of five face-to-face monitoring visits are billable per year for each eligible beneficiary. To be reimbursed, the visit must be face-to-face. Additional monitoring and follow-up activities are likely between face-to-face visits, but are not reimbursable. At least one annual face-to-face monitoring visit should be conducted to determine whether the following conditions are met:

- Services are being furnished in accordance with the beneficiary's Plan of Care;
- Services in the Plan of Care are adequate; and
- Changes in the needs or status of the beneficiary are reflected in the Plan of Care.

Monitoring and follow-up activities include making necessary adjustments in the Plan of Care and service arrangements with providers.

III. Accessing Services

Accessing TCM services may occur a number of ways. If the beneficiary is an MHP member, the MHP may initiate the initial contact with the beneficiary and identify those beneficiaries that may benefit from TCM services. Fee-for-Service (FFS) and MHP beneficiaries may also access TCM services either through a referral from their PCP or through a self-referral.

IV. Covered Supports and Services

A maximum of six face-to-face visits per year will be reimbursed for each eligible beneficiary as follows:

- One visit for the initial/annual comprehensive assessment.
- A maximum of five visits for monitoring and follow-up.

For additional visits, the Michigan Department of Health and Human Services (MDHHS) requires the provider to obtain prior authorization before the service is rendered. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information regarding prior authorizations, found at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual.)

Reimbursement for assessment and monitoring visits is inclusive of all related care coordination and monitoring activities. MDHHS does not reimburse for missed appointments/visits. A beneficiary may not be billed for a missed appointment/visit.

Medicaid reimbursement for TCM services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Case management includes contacts with non-eligible beneficiaries when the contact is:

- Directly related to identifying the eligible beneficiary's needs and care, for the purpose of assisting the beneficiary in accessing services;
- Identifying needs and supports to assist the beneficiary in obtaining services;
- Providing case managers with useful feedback; and
- Alerting case managers to changes in the beneficiary's needs.

Case management does not include activities that constitute the direct delivery of underlying medical, educational, social, and/or other services to which an eligible beneficiary has been referred, including foster care programs and 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; and
- Making placement arrangements.

V. Transfer of Care/Records

During the course of care, the beneficiary may require services from a different case manager due to relocation of the beneficiary's primary residence or due to a request of the beneficiary to change case managers. When there is a planned change of the case manager, information about the new case manager (e.g., contact information) should be provided to the beneficiary. The referring case manager must consult with the new case manager about the case and transfer all applicable information and records, including all completed assessment visits and the updated Plan of Care, to the new case manager in compliance with the privacy and security requirements of federal and state laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code.

VI. TCM Closure

TCM services are available to all eligible beneficiaries up to age 21, or for pregnant women up to and through 60 days post-delivery. TCM services will be discontinued if the beneficiary is no longer eligible; when the beneficiary, parent(s), or guardian(s) refuses the service; or if CMS does not extend the Flint, Michigan Section 1115 Demonstration Waiver. When services are refused, TCM services may be resumed at any point during the defined period of eligibility. A discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and provided to the PCP when the TCM case is closed.

VII. Provider Qualifications

Genesee Health System, the local community mental health (CMH) serving Genesee County, will serve as the Designated Provider Organization (DPO) for TCM services. The DPO:

- Has a sufficient number of qualified staff to meet the service needs of the target population and has the administrative capacity to ensure the provision of quality services in accordance with state and federal requirements;
- Has experience in the coordination and linkage of community services;
- Has the willingness and capabilities to coordinate with the beneficiary's PCP and MHP as applicable; and
- Must seek approval by MDHHS of all subcontractors for the provision of TCM services.

The DPO will provide TCM services primarily through the use of a case manager. The case manager must meet one of the following professional qualifications:

- Licensure as a registered nurse by the Michigan Department of Licensing and Regulatory Affairs (LARA) and at least one year of experience providing community health, pediatric or maternal infant health nursing services; or
- Licensure as a social worker by LARA and at least one year of experience providing social work services to families.

VIII. Claims Submission and Payment

All claims submitted and accepted are processed through CHAMPS. Claims must be submitted on the ASC X12N 837 5010 professional format when submitting electronic claims or on the CMS 1500 claim form for paper claims. Information regarding billing is available in the Billing & Reimbursement for Professionals Chapter of the Michigan Medicaid Provider Manual.

A. Initial/Annual Assessments (One per year per family/household)

Face-to-face assessment visit to be billed using T2024, with one rate set at $201.58 for an individual or family. This rate includes reimbursement for development of a Plan of Care for one individual. Bill T2024 with modifier TT (Additional patient), rate set at $100, for each additional individual Plan of Care that is developed from the assessment visit. For informational/reporting purposes use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), US (six or more patients served).

Assessment visits must be in the home or “home-like” environment. Additional assessment visits beyond one per year per family/household require prior authorization.

B. Follow-up/Monitoring (Maximum of five per year per beneficiary)

Face-to-face follow-up/monitoring visits are to be billed using T1017, rate set at $201.58 for an individual or family. For informational/reporting purposes use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), US (six or more patients served), and enter the beneficiary ID numbers of the family members served during the follow-up visit in the claim notes.

Follow-up visits must last at least 30 minutes and ideally take place in the home or “home-like” environment, but may be performed in the office. Additional follow-up visits beyond five per year per beneficiary require prior authorization.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Matthew Hambleton
MDHHS/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: HambletonM@michigan.gov

If responding by e-mail, please include "Coverage of Targeted Case Management Services Under the Flint Waiver" in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

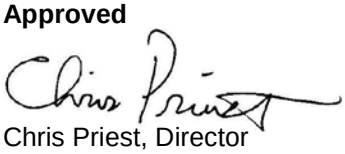
Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Chris Priest, Director
Medical Services Administration