SECTION 2

TARGETED CASE MANAGEMENT FOR THE HOMELESS

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1 GENERAL POLICY

Targeted case management is a service that assists eligible Medicaid clients in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid clients to access needed services, but to ensure that services are coordinated among all agencies and providers involved.

1 - 1 Authority

The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272, COBRA) added targeted case management to the list of optional services which can be provided under the State Medicaid Plan.

1 - 2 Definitions

CHEC: means Child Health Evaluation and Care and is Utah's version of the federally mandated Early Periodic screening Diagnosis and Treatment (EPSDT) program. All Medicaid eligible clients from *birth through age twenty* are enrolled in the CHEC program. The only exception to this policy is that Medicaid clients age 19 and older enrolled in the Non-Traditional Medicaid Plan are **not** eligible for the CHEC program. The Medicaid Identification Cards for individuals enrolled in the Non-Traditional Medicaid Plan are blue in color and specify that the individual is enrolled in this plan.

DHCF: means the Division of Health Care Financing in the Utah Department of Health that is responsible for implementing, organizing and maintaining the State's Medicaid program.

1 - 3 Target Group

A. Targeted case management services may be provided to homeless Medicaid clients for whom the service is determined to be medically necessary. Targeted case management services are medically necessary when a comprehensive needs assessment shows:

1. the individual requires treatment and/or services from a variety of agencies and providers to meet his or her documented medical, social, educational and other needs; and

2. there is a reasonable indication that the individual will access needed treatment or services only if assisted by a qualified targeted case manager who locates, coordinates and regularly monitors the services in accordance with an individualized case management service plan.

B. General Limitations:

Targeted case management services are limited to:

1. Non-Traditional Medicaid Plan clients– Medicaid clients in the Non-Traditional Medicaid Plan (TANF and medically needy adults age 19 and over). These clients' Medicaid cards are blue and have 'Non-Traditional Medicaid Plan' listed on them.

2. Traditional Medicaid Plan clients– Prior to January 15, 2003, all Traditional Medicaid Plan clients were eligible for this service.

   Effective January 15, 2003, only Medicaid clients who are pregnant or under age 21 are eligible for this service. Targeted case management services may be provided to Medicaid-eligible children when the case management activity is specific to helping the child access needed services.

   Traditional Medicaid Plan clients have lavender Medicaid cards and there is a "(F)" after their Medicaid ID Number.

C. Homeless individuals are those who:

1. Reside in a Salt Lake, Summit, Wasatch, Weber, or Utah County emergency homeless shelter capable of providing temporary shelter for at least 30 days in order to assure that sufficient case management services are provided to successfully reintegrate the homeless into the community;

2. Do not otherwise have a permanent address or residence in which they could reside; and

3. Do not live in a boarding home, residential treatment facility or facility which houses only victims of domestic abuse; or

4. Have left the homeless shelter and require continued targeted case management services to prevent a recurrence of homelessness.

D. Currently, the Utah Medicaid program provides coverage of targeted and home and community based waiver services (HCBS) case management for a variety of other target groups:

1. Individuals with Substance Abuse Disorders;
2. Early Childhood (0-4);
3. Individuals with Chronic Mental Illness;
4. Individuals with a diagnosis of HIV/AIDS;
5. Individuals with Physical Disabilities (HCBS Waiver);
6. Individuals with Mental Retardation/Related Conditions (HCBS Waiver);
7. Individuals Aged 65 and over (HCBS Waiver);
8. Technology-Dependent Children (HCBS Waiver); and
9. Individuals with Traumatic Brain Injury (HCBS Waiver).

There are separate rules and provider manuals which address the scope of services and reimbursement methods for these other target groups. Please note that since a Medicaid client may qualify for targeted or waiver case management services under other target groups, it is imperative that before providing services, the case manager determines if other agencies are already providing targeted or waiver case management for the client, as only one targeted case management provider will be reimbursed for the same or overlapping dates of service. Coordination of all services is an essential component of targeted case management.

1 - 4 Qualified Targeted Case Management Providers

Qualified providers include an individual who is:

1. a licensed physician, a licensed psychologist, a licensed clinical social worker, a licensed certified social worker, a licensed social service worker, a licensed advanced practice registered nurse, a licensed registered nurse, a licensed practical nurse, a licensed professional counselor, a licensed substance abuse counselor, a licensed marriage and family counselor; or

2. an individual working toward licensure in one of the professions identified in #1 above; or

3. a non-licensed individual working under the supervision of one of the individuals identified in #1 or #2 above.

See Title 58, Chapter 60, of the Utah Code Annotated for the applicable practice act, or the practice act rule for **any** supervision requirements.

1 - 5 Client Rights

A. Targeted case management services may not be used to restrict the client's access to other services available under the Medicaid State Plan.

B. The provider agency must have a process to ensure that the client, or the client's guardian if applicable, voluntarily chooses targeted case management services and is given a choice in the selection of the targeted case manager.

2 SCOPE OF SERVICE

2 - 1 Covered Services and Activities

A. Targeted case management is a service to assist Medicaid clients in the target group to gain access to needed medical, social, educational, and other services. The goal of the service is not only to help Medicaid clients to access needed services, but also to ensure that services are coordinated among all agencies and providers involved.

B. Medicaid reimbursement for targeted case management is dictated by the nature of the activity and the purpose for which the activity was performed. When billed in amounts that are reasonable (given the needs and condition of the particular client), the following activities/services are covered by Medicaid under targeted case management:

1. assessing the client to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessment activities include: taking client history, identifying the needs of the client and completing related documentation, gathering information from other sources such as family members, medical providers, social workers, other providers, and educators, if necessary, to form a complete assessment of the client;

2. developing a written, individualized, and coordinated case management service 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 client, with input from the client, the client's authorized health care decision maker, and others (e.g., the client's family, other agencies, etc.) knowledgeable about the client's needs, to develop goals and identify a course of action to respond to the assessed needs of the client;

3. referral and related activities to help the client obtain needed services, including activities that help link the client with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers of needed services and scheduling appointments for the client;

4. assisting the client to establish and maintain eligibility for entitlements **other than Medicaid**;

5. coordinating the delivery of services to the client, including CHEC screenings and follow-up;

6. contacting non-eligible or non-targeted individuals when the purpose of the contact is directly related to the management of the client's care. For example, family members may be able to help identify needs and supports, assist the client to obtain services, provide case managers with useful feedback and alert them to changes in the client's status or needs;

7. instructing the client or caretaker, as appropriate, in independently accessing needed services;

8. monitoring and follow-up activities, including activities and contacts that are necessary to ensure the targeted case management service plan is effectively implemented and adequately addressing the needs of the client, which activities may be with the client, family members, providers or other entities, and conducted as frequently as necessary to help determine such matters as whether services are being furnished in accordance with the client's case management service plan, whether the services in the case management service plan are adequate, whether there are changes in the needs or status of the client, and if so, making necessary adjustments in the case management service plan and service arrangements with providers; and

9. monitoring the client's progress and continued need for targeted case management and other services.

C. The agency may bill Medicaid for the above services and activities only if:

1. the services and activities are identified in the case management service plan;

2. the time spent in the service or activity involves a face-to-face encounter, telephone or written communication with the client, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the client obtains the necessary services documented in the targeted case management service plan; and

3. there are no other third parties liable to pay for such services, including reimbursement under a medical, social, education, or other program.

D. Covered targeted case management services provided to patients in a hospital or nursing facility are covered only during the 30-day period prior to the patient's discharge into the community, and are limited to three hours of reimbursement per patient per year.

2 - 2 Non-Covered Services and Activities

In accordance with federal Medicaid guidelines, ***the following activities are not considered targeted case management and should not be billed to Medicaid:***

A. documenting targeted case management services - with the exception of time spent developing the written needs assessment, service plan, and 180-day service plan review - is not reimbursable as targeted case management.

B. teaching, tutoring, training, instructing, or educating the client or others, except in so far as the activity is specifically designed to assist the client, parent, or caretaker to independently obtain needed services for the client.

   For example, assisting the client to complete a homework assignment, or instructing a client or family member on nutrition, budgeting, cooking, parenting skills or other skills development is not reimbursable as targeted case management;

C. directly assisting with personal care or activities of daily living (bathing, hair or skin care, eating, etc.) or instrumental activities of daily living (assisting with budgeting, cooking, shopping, laundry, home repairs, apartment hunting, moving residences, or acting as a protective payee) are not reimbursable activities under targeted case management;

D. performing routine services including courier services. For example, running errands or picking up and delivering food stamps or entitlement checks are not reimbursable as targeted case management;

E. direct delivery of an underlying medical, education, social, or other service to which the client has been referred, or provision of a Medicaid-covered service. For example, providing medical and psycho-social evaluations, treatment, therapy and counseling that are otherwise billable to Medicaid under other categories of service, are not reimbursable as targeted case management;

F. direct delivery of foster care services, including but not limited to research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care placements, serving legal papers, home investigations, providing transportation, administering foster care subsidies or making foster care placement arrangements;

G. traveling to the client's home or other location where a covered case management activity will occur is not reimbursable, nor is time spent transporting a client or a client's family members;

H. providing services for or on behalf of other family members who do not directly assist the client to access needed services. For example, counseling the client's sibling or helping the client's parent obtain a mental health service are not reimbursable as targeted case management;

I. performing activities necessary for the proper and efficient administration of the Medicaid State Plan, including assisting the client to establish and maintain Medicaid eligibility. For example, locating, completing and delivering documents to the Medicaid eligibility worker is not reimbursable as targeted case management;

J. recruitment activities in which the center or case manager attempts to contact potential recipients of service are not reimbursable as targeted case management;

K. time spent assisting client to gather evidence for a Medicaid hearing or participating in a hearing as a witness is not reimbursable as targeted case management; and

L. time spent coordinating between case management team members for a client is a non-billable activity.

2 - 3 Limitations on Reimbursable Services

A. The agency may bill Medicaid for the covered services and activities specified in Chapter 2-1, Section B, only if:

1. the services and activities are identified in the targeted case management service plan;

2. the time spent in the service or activity involves a face-to-face encounter, telephone or written communication with the client, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the client obtains the necessary services documented in the targeted case management service plan; and

3. there are no other third parties liable to pay for such services, including reimbursement under a medical, social, education, or other program.

B. The agency may not bill Medicaid for the covered services and activities specified in Chapter 2-1, Section B, if no payment liability is incurred. Medicaid reimbursement is not available for services provided free-of-charge to non-Medicaid recipients.

C. Team Case Management

Targeted case management services provided to a client by more than one case manager employed by the center are reimbursable only under the following conditions:

1. all members of the team meet the qualifications described in Chapter 1 - 4;

2. documentation of billed services is maintained in a single case file;

3. all services are delivered under a single case management service plan;

4. all team members coordinate with one another to ensure only necessary, appropriate, and unduplicated services are being delivered by all team members;

5. time spent by two or more members of the team in the same targeted case management activity may be billed only by one team case manager; and

6. the recipient is informed and understands the roles of the team members.

D. Shared Case Management

Targeted case management services billed by case managers from more than one agency or program during the same or overlapping dates of service for the same client will be considered for reimbursement only if the DHCF has received documentation to support the need for the expertise of two case management providers. A letter signed by the case managers of both agencies must be submitted to the DHCF. The letter must (1) fully explain the need for shared case management, (2) document the specific and non-duplicative services to be provided by each case manager, (3) specify the time period during which shared case management will be required, and (4) include a copy of the needs assessments and service plans from both case managers.

NOTE: The DHCF will not approve shared case management for a client receiving home and community-based waiver services. Time spent on behalf of a client receiving home and community-based waiver case management services is not reimbursable as targeted case management, nor may the time spent by a targeted case manager be billed by a waiver case manager.

See General Limitations in Chapter 1 - 3.

3 RECORD KEEPING

3 - 1 Required Documentation

A. The case manager must develop and maintain sufficient written documentation for each unit of targeted case management services billed. Documentation must include at least the following:

Record: For each contact:

1. name of client;
2. date and actual time of service;
3. duration of the service;
4. units of service;
5. setting in which the service was rendered;
6. description of the case management activity as it relates to the service plan; and
7. signature of the individual providing the service;

B. Targeted case management services must be documented in 15 minute intervals.

C. The following documents must be contained in each client's case file:

1. a written, individualized needs assessment that documents the client's need for targeted case management services;
2. a written, individualized targeted case management service plan that identifies the services (i.e., medical, social education, and other services) the client is to receive, who will provide them, and a general description of the targeted case management activities needed to help the client obtain or maintain these services; and
3. a written review of the service plan, every 180-days, summarizing the client's progress toward targeted case management service plan objectives. The service plan review must be completed within the month due, or more frequently as required by the client's condition.

Unit: T1017 **- Targeted Case Management -** per 15 minutes per client.

When billing or reporting this procedure code, round to the nearest full unit. For example, 22 minutes of service equals 1 unit; 23 minutes of service equals 2 units.

Limits: See Chapter 2-1 and Chapter 2-2 for limitations on this service.

4 SERVICE PAYMENT

4 - 1 Payment Methodology

A. Payment for targeted case management services is made on a fee-for-service basis.

B. Rates are based on a 15-minute unit of service.

5 PROCEDURE CODES FOR TARGETED CASE MANAGEMENT FOR THE HOMELESS

For each date of service, enter the appropriate five digit procedure code as indicated below:

CODE	SERVICE AND UNITS	LIMITS PER PATIENT
T1017	Targeted Case Management, per 15 minutes	No limit. Exception - when providing inpatient services, limited to 3 hours per patient per year. See Chapter 2-1, D.

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