# MEDICAID POLICY INFORMATION SHEET

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Initial ☐ Public Comment ☒ Final ☐

**Brief description of policy:**

The purpose of this bulletin is to establish coverage and reimbursement of Targeted Case Management (TCM) Services for Children's Special Health Care Services (CSHCS) beneficiaries with qualifying medical complexity and fragility and who are under 21 years of age. Program coverage of Children with Medical Complexity Targeted Case Management (CMC TCM) Services is effective for dates of service on or after August 1, 2024. CMC TCM services are carved out of the Medicaid Health Plan (MHP) coverage and reimbursed as a Fee for Service (FFS), consistent with applicable Medicaid policy.

**Reason for policy (problem being addressed):**

Children with medical complexity (CMC) are a small but growing subset of children with special needs. CMC have significant chronic conditions that involve multiple organ systems, substantial health service needs, major functional limitations, and high health care resource use. A growing body of evidence indicates that intensive care coordination is an effective strategy for addressing these challenges, as well as for improving health outcomes and decreasing hospitalization costs. State Plan authority is needed to provide reimbursement for CMC TCM services to eligible providers.

**Budget implication:**

☒ budget neutral
☐ will cost MDHHS $ , and (select one) budgeted in current appropriation
☐ will save MDHHS $

**Is this policy change mandated per federal requirements?**

No

**Does policy have operational implications on other parts of MDHHS?**

No

**Does policy have operational implications on other departments?**

No

**Summary of input:**

☐ controversial (Explain)
☒ acceptable to most/all groups
☐ limited public interest/comment

**Supporting Documentation:**

| | |
|---|---|
| State Plan Amendment Required: ☒ Yes ☐ No<br>If Yes, please provide status:<br>☐ Approved ☒ Pending ☐ Denied<br>Date: Approval Date: | Public Notice Required: ☒ Yes ☐ No<br><br>If yes,<br>Submission Date: |

| DRAFT FOR PUBLIC COMMENT | | |
|---|---|---|
| **Michigan Department of Health and Human Services** | **Project Number:** 2409-CSHCS | **Date:** May 2, 2024 |

**Comments Due:** June 6, 2024
**Proposed Effective Date:** August 1, 2024
**Direct Comments To:** Theresa Christner
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**Policy Subject:** Targeted Case Management Services for Children's Special Health Care Services (CSHCS) Enrollees with Medical Complexity

**Affected Programs:** Medicaid, Healthy Michigan Plan, MIChild, CSHCS

**Distribution:** All Providers

**Summary:** This bulletin establishes coverage for Children with Medical Complexity Targeted Case Management (CMC TCM) program services for CSHCS enrollees under the age of 21 years and who meet additional complexity and fragility criteria, including: chronic condition(s) that involve three or more organ systems and result in technology dependency or transplantation, functional limitations, medication, durable medical equipment, therapy, surgery, and other treatments. Additionally, eligible beneficiaries must also meet one of the following utilization criteria during the previous 12 months: one or more hospitalizations with a length of stay of five days or more; **or** ten or more visits to a tertiary specialty clinic. CMC TCM program services will be carved out of the Medicaid Health Plan coverage and reimbursed through the Medicaid fee-for-service (FFS) program.

**Purpose:** CMC are a small but growing subset of children with special needs. Intensive care coordination is an effective strategy for addressing these challenges, as well as for improving health outcomes and decreasing hospitalization costs.

**Cost Implications:** Budget neutral

**Potential Hearings & Appeal Issues:** Beneficiary eligibility

| | |
|---|---|
| **State Plan Amendment Required: Yes** ☒ **No** ☐<br>**If yes, date submitted:** Pending | **Public Notice Required: Yes** ☒ **No** ☐<br>**Submitted date:** Pending |

**Tribal Notification: Yes** ☒ **No** ☐ **- Date:** April 22, 2024

**THIS SECTION COMPLETED BY RECEIVER**

| | |
|---|---|
| ☐ **Approved** | ☐ **No Comments** |
| | ☐ **See Comments Below** |
| ☐ **Disapproved** | ☐ **See Comments in Text** |

| **Signature:** | **Phone Number** |
|---|---|
| | |

| **Signature Printed:** | |
|---|---|
| **Bureau/Administration** *(please print)* | **Date** |

**Comment001** **Revised 6/16**

# Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

**Distribution:** All Providers

**Issued:** July 1, 2024 (Proposed)

**Subject:** Targeted Case Management Services for Children's Special Health Care Services (CSHCS) Beneficiaries with Medical Complexity

**Effective:** August 1, 2024 (Proposed)

**Programs Affected:** Medicaid, Healthy Michigan Plan, MIChild, CSHCS

**NOTE: Implementation of this policy is contingent upon approval of a State Plan Amendment (SPA) by the Centers for Medicare & Medicaid Services (CMS).**

The purpose of this bulletin is to establish coverage and reimbursement of Targeted Case Management (TCM) Services for Children's Special Health Care Services (CSHCS) beneficiaries with qualifying medical complexity. Coverage of Children with Medical Complexity Targeted Case Management (CMC TCM) services is effective for dates of service on or after August 1, 2024. CMC TCM services are carved out of the Medicaid Health Plan's capitation and are billed and reimbursed as a fee-for-service benefit, consistent with applicable Medicaid policy.

In addition to this policy, a website will be established where the CMC TCM Provider Handbook will be made available. The CMC TCM Provider Handbook will assist CMC TCM providers in complying with the requirements of the CMC TCM policy and SPA, as well as aid them in offering CMC TCM services in accordance with accepted standards, applicable policies/procedures, and best practices.

Children with medical complexity (CMC) are a small but growing subset of children with special needs. CMC have significant chronic conditions that involve multiple organ systems, substantial health service needs, major functional limitations, and high health care resource use. A growing body of evidence indicates that intensive care coordination is an effective strategy for addressing these challenges.

## I. General Information

CMC TCM services provide eligible beneficiaries with medical complexity who are enrolled in the CSHCS program with intensive case management and service coordination. The CMC TCM provider functions as the central point of contact for comprehensive, individualized care across the broader health care system. Eligible beneficiaries work with a

multi-disciplinary care team of providers to receive the core elements of CMC TCM services:

- assessment;
- plan of care;
- referral and coordination services; and
- monitoring/follow-up activities.

This integrated case management model is intended to improve access to services for eligible beneficiaries with chronic physical and mental health conditions, while also addressing their social determinants of health.

## II. Beneficiary Eligibility

CMC TCM services are **voluntary** services available to CSHCS beneficiaries under 21 years of age who meet **all** the following specified chronicity, complexity, and fragility criteria for their CSHCS qualifying diagnosis(es):

- diagnosed with one or more chronic conditions, involving three or more body organ systems;
- have functional limitations and are technologically dependent and/or a transplant candidate;
- require the use of medication, durable medical equipment (DME), therapy, surgery, or other treatments; and
- receive treatment from three or more medical or surgical specialties at the enrolled tertiary hospital or medical university with pediatric medical and surgical specialty areas.

Additionally, eligible beneficiaries must also meet **at least one** of the following utilization criteria during the previous 12 months:

- one or more hospital admissions, each resulting in a length of stay of five days or more; or
- ten or more visits to tertiary specialty clinics (clinic visits count only if they are with a medical or surgical subspecialist).

Beneficiaries who are too young to have met the utilization criteria may be eligible if they meet the above health condition criteria and **both** of the following:

- a stay in the hospital totaling five or more days; and
- clinicians anticipate that the beneficiary will be an intensive user of health resources (i.e., is expected to meet utilization criteria).

CMC TCM services are not available for the following:

- inmates of public institutions;

- beneficiaries who are receiving mental and/or behavioral health case management services;
- beneficiaries who qualify for CMC TCM services, but have opted to receive CSHCS local health department (LHD) case management services;
- beneficiaries receiving the MI Care Health Home, Behavioral Health Home, or Opioid Health Home benefits;
- beneficiaries receiving Collaborative Care Management services; or
- beneficiaries who are dually enrolled in Medicaid and CSHCS and receive similar case management services from another provider.

## III. Enrollment

### A. Provider Referrals

Eligible beneficiaries who meet the criteria for the CMC TCM services will be identified through a referral and screening process that is completed on-site by the CMC TCM core team.

Physicians who are knowledgeable of chronic complex physical health conditions, understand the benefits of intensive case management/care coordination services, and/or have treated the beneficiary may submit referrals. The CMC TCM core team will consider referrals made by the following qualified health professionals:

- specialists/subspecialists
- emergency room physicians
- primary care physicians

### B. Eligibility Determination

Upon receipt of the referral, the CMC TCM core team confirms the beneficiary's eligibility for CMC TCM services through a review of the beneficiary's medical records and utilization data. The CMC TCM core team notifies both the referring provider and the beneficiary and/or parent/guardian of their eligibility status. Eligible beneficiaries and their parents/guardians are offered a choice to receive the CMC TCM services, as well as provided a list of available CMC TCM providers.

Eligibility notifications must be in writing and provide information about the beneficiary's right to appeal decisions and/or modifications of services. (Refer to the Appeals Section of the Children's Special Health Care Services chapter of the MDHHS Medicaid Provider Manual for additional information).

**Primary Point of Contact and Initial Meeting**

Upon completion of the eligibility determination process, eligible beneficiaries will be provided a CMC TCM primary point of contact who is a member of the CMC TCM core team. The primary point of contact schedules an initial intake meeting with the beneficiary. The initial meeting should be a face-to-face contact.

The purpose of the initial meeting includes, but is not limited to:

- confirming voluntary enrollment and provider selection;
- educating the beneficiary and/or parent/guardian about the CMC TCM services and answering questions;
- collecting the beneficiary's demographic and beneficiary contact information, current legal status, medical and behavioral health history;
- completing needed authorizations related to the sharing of protected health information; and
- scheduling the initial in-person comprehensive assessment with the CMC TCM core team.

## C. Beneficiary Consent

Prior to receiving the CMC TCM services, beneficiaries and/or parents/guardians must select the CMC TCM provider of their choice and sign the CMC TCM Informed Consent and Authorization Form. The CMC TCM provider adds his/her signature to the form to acknowledge that the beneficiary has been accepted and submits the form to CSHCS through its Document Management Portal (DMP). The form must be signed by both the CMC TCM medical director and the beneficiary and/or his/her parent/guardian. A webpage will be established where the Informed Consent and Authorization form will be made available.

Upon receipt of the Informed Consent and Authorization Form, CSHCS will add the CMC TCM provider to the beneficiary's file in the CSHCS database. It is incumbent upon the CMC TCM providers to verify their authorization prior to rendering services. CMC TCM providers who are not authorized to provide services for a beneficiary will not be eligible for CMC TCM payment.

## D. Transfer of Care

During care, the beneficiary may require services from a different CMC TCM provider due to relocation of the beneficiary's primary residence or due to a request by the beneficiary and/or parent/guardian to change CMC TCM providers. The referring CMC TCM provider must consult with the new CMC TCM provider about the case and transfer all applicable information and case records, including all completed assessments and the updated comprehensive, individualized plan of care, to the new CMC TCM provider.

Protected health information (PHI), personally identifiable information (PII), and sensitive or confidential information should only be shared 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 and using the most secure method and appropriate encryption standards. Only the minimum amount of PHI, PII, sensitive or confidential information necessary should be shared with the new CMC TCM provider.

## E. CMC TCM Renewal

The beneficiary's continued involvement in the CMC TCM services is contingent upon their successful renewal in CSHCS. The comprehensive assessment offers the opportunity for the CMC TCM core team and beneficiary and/or parent/guardian to discuss the beneficiary's continued need for intensive case management services. If the beneficiary and/or parent/guardian do not participate in the completion of a comprehensive assessment and/or development of the comprehensive, individualized plan of care, or if the CMC TCM medical director no longer can attest that the beneficiary needs or benefits from CMC TCM services, services will be terminated.

Additionally, if a beneficiary does not receive a billable service within a six-month timeframe, the beneficiary should be removed from the monthly enrollment report. Once services are terminated, the beneficiary will need to have their CMC TCM eligibility redetermined to resume CMC TCM services, unless otherwise approved by MDHHS.

## F. CMC TCM Case Closure

CMC TCM providers may not compel a beneficiary to accept CMC TCM services. Beneficiaries receiving CMC TCM services and/or their parent/guardian may decide to opt out at any time. The beneficiary and/or parent/guardian indicates voluntary participation in CMC TCM services by signing an informed consent and authorization form and maintaining contact with and receiving services from the CMC TCM core team. If a beneficiary and/or their parent/guardian declines CMC TCM services, the CMC TCM core team is required to document that in the beneficiary's case record.

Beneficiaries who are notified of CMC TCM eligibility and choose not to receive CMC TCM services at that time, may elect to receive CMC TCM services in the future if they continue to meet the eligibility criteria. Beneficiaries who decline or choose not to receive services may do so without jeopardizing their access to other necessary medical services. Beneficiary participation in services may be terminated when the beneficiary reaches age 21 years, becomes ineligible for Medicaid and/or CSHCS, transitions into hospice, dies, or if the CMC TCM core team terminates the beneficiary's participation in services for fraud, abuse, misconduct, or other reasons.

If the CMC TCM core team needs to reduce or terminate CMC TCM services for any reason, the CMC TCM core team is required to notify the beneficiary and/or parent/guardian 30 days before the reduction or termination, document the reason for the reduction/termination in the beneficiary's comprehensive, individualized plan of care, and advise of appeal rights for any reduction/termination.

### G. Duplication of Services

Beneficiaries must not receive case management and care coordination services from more than one case management provider. The preferences of the beneficiary/parent/guardian concerning which agency provides services must be considered when the roles overlap.

i. Medicaid Health Plan (MHP) Coordination

The CMC TCM services are carved out of the MHP contract. CMC TCM providers must establish a process for the CMC TCM core team to communicate with health plan staff on a quarterly basis to identify CSHCS health plan beneficiaries receiving CMC TCM services, to share assessments and comprehensive, individualized plans of care, and to ensure no service duplication occurs for mutually served beneficiaries.

## IV. Core Elements of CMC TCM Services

CMC TCM services are multi-disciplinary, team-based services that may be accessed in multiple settings, including the clinic or home, and either in-person or via telemedicine. CMC TCM services focus on the completion of a comprehensive assessment to identify CMC needs. Guided by the outcome of this assessment, the CMC TCM core team works with the beneficiary and/or parent/guardian to develop a comprehensive, individualized plan of care that reflects the input and involvement of the beneficiary and/or parent/guardian. Ongoing care coordination, comprehensive transitional care, support and/or referrals to medical, behavioral, school and/or community-based support services, as well as ongoing monitoring and follow-up activities are provided through the collaborative efforts of the CMC TCM core team.

### A. Comprehensive Assessment

Case management services include a comprehensive assessment to determine the beneficiary's need for medical, educational, social, and/or other services.

The assessment must be a written document. Comprehensive assessments are covered no more than once every two (2) years from the date of the initial comprehensive assessment, unless otherwise approved by MDHHS. The initial comprehensive assessments must be an in-person visit. The purpose of the initial comprehensive assessment is to gather sufficient information to develop a comprehensive, individualized plan of care for the beneficiary.

i. Case Management Documentation

CMC TCM core team is required to maintain case records for each beneficiary receiving CMC TCM services. The CMC TCM core team must document the date of all contacts in the beneficiary's case record.

## B. Comprehensive, Individualized Plan of Care Development

Following the assessment, the CMC TCM core team must develop and document a comprehensive, individualized plan of care based on the information collected from the comprehensive assessment. At a minimum, the plan of care must:

- specify goals and objectives to address the medical, social, educational and any other identified needs, including social determinants of health;
- identify a course of action to respond to the beneficiary's assessed needs;
- include the duration, scope and amount of services needed, as well as identify the service provider and timeframes for initiating and/or completing the identified actions;
- describe the responsibilities of the beneficiary/parent/guardian associated with accomplishing the comprehensive, individualized plan of care; and
- periodically, and at least quarterly, document progress toward achieving specified goals and objectives.

The CMC TCM core team must work with the beneficiary and/or their parent/guardian to develop the plan's goals/objectives and to identify a course of action to respond to the beneficiary's assessed needs. The comprehensive, individualized plan of care should address the physical and behavioral health needs of the beneficiary, along with any other needed resources such as housing, energy assistance, food and nutrition, vocational training, cultural and spiritual needs, and transportation needs. The plan of care should also address emergency situations and/or determine the steps to take during the exacerbation of symptoms. The CMC TCM core team should share the plan of care with the beneficiary/parent/guardian, and others, including medical and social service providers, as applicable and allowable.

The entire CMC TCM core team is required to be part of the in-person team visit with the beneficiary and/or parent/guardian when developing the comprehensive, individualized plan of care plan. To the maximum extent possible, the CMC TCM core team is required to ensure that the beneficiary and/or parent/guardian are actively involved in the development of the plan of care.

At a minimum, the comprehensive, individualized plan of care must be reviewed and/or updated quarterly depending on the needs of the beneficiary. Periodic reviews and updates of the plan of care are covered as ongoing monitoring and follow-up activities.

## C. Referrals and Care Coordination Services

Working collaboratively with the beneficiary/parent/guardian, their specialists/subspecialists, and their primary care and/or other health care providers, members of the CMC TCM core team will facilitate and coordinate the service(s) detailed in the comprehensive, individualized plan of care. The CMC TCM core team will also assist with referrals and other related activities to support the beneficiary in obtaining needed services, as chosen. Ongoing referral and service coordination activities include face-to-face, and/or reciprocal telephonic or written contacts with, or on behalf of, the beneficiary/parent/guardian.

## D. Monitoring and Follow-up Activities

Monitoring and follow-up activities include activities and contacts that are necessary to ensure the comprehensive, individualized plan of care is implemented and adequately addresses the beneficiary's needs. Monitoring activities may be conducted with the beneficiary/parent/guardian, service providers, or other entities. Monitoring and follow-up activities also include ensuring that changes in the needs or status of the beneficiary are reflected in the plan of care, and that the beneficiary can access services and/or is receiving the services as specified in the plan of care.

Ongoing monitoring and follow-up activities include face-to face encounters, and/or reciprocal telephonic or written contact with, or on behalf of, the beneficiary/parent/guardian. Telemedicine visits may be provided at the discretion of the beneficiary and/or the beneficiary's parents/guardians. At least one in-person monitoring visit should occur annually for the purpose of determining if the services and supports have been delivered, are adequate to meet the needs/wants of the beneficiary and to make any necessary adjustments in the comprehensive, individualized plan of care.

i. <u>Frequency of Monitoring and Follow-up Activities</u>

Monitoring shall occur monthly, and more often if needed, to ensure the beneficiary's needs are met and to maintain a continuing relationship between the beneficiary, their parent/guardian, and any providers responsible for services. Frequency and scope of case management monitoring and follow-up activities must reflect the intensity of the beneficiary's physical health, behavioral health, and welfare needs identified in the comprehensive, individualized plan of care. The CMC TCM core team is required to discuss and document the proposed frequency of contacts with the beneficiary and/or their parent/guardian. The discussion must include the frequency of contacts with the beneficiary, any providers instrumental to the implementation of the plan of care, and any other individuals directly related to implementing services and supports on behalf of the beneficiary.

If the frequency of contacts will be less than a monthly visit or reciprocal contact, the CMC TCM core team is required to note the reason in the beneficiary's case record.

### E. Service Availability and Accessibility

CMC TCM services must be available and accessible 24 hours per day for a beneficiary and/or their parent/guardian from a CMC TCM core team member.

### F. Excluded Services

CMC TCM does not include activities that constitute the direct delivery of underlying medical, educational, social, and/or other services to which a beneficiary has been referred. Furthermore, case management services do not include activities that are an integral and inseparable component of another Medicaid-covered service.

Medical services provided by CMC TCM core team members must be within their scope of practice, in consultation with the beneficiary's specialists, and at the request of the beneficiary and/or his/her parent/guardian. Allowable medical services are billed separately and in accordance with established Medicaid/CSHCS policy.

## V. CMC TCM Provider Service Qualifications

The CMC TCM provider must be a Michigan Medicaid enrolled tertiary hospital or medical university with pediatric medical and surgical specialty areas. CMC TCM providers are limited to one program per facility. In addition, the approved tertiary hospital/medical university is required to obtain a separate National Provider Identifier (NPI) number to enroll and submit claims specifically for the CMC TCM services and must identify the providers who render the services as affiliated providers.

CMC TCM providers will be required to complete a CMC TCM Readiness Assessment, attesting that they are able to meet the requirements of the CMC TCM provider qualifications to be officially recognized as a CMC TCM provider. CMC TCM providers sign the CMC TCM Readiness Assessment agreeing to adhere to this policy, the SPA, and other applicable MDHHS policies and procedures, and return the signed form to MDHHS. A CMC TCM provider may become designated as a TCM provider only after MDHHS receives and approves the signed attestation which is uploaded to CSHCS program through the Document Management Portal. A website will be established where the CMC TCM Provider Readiness Assessment form will be made available. (Refer to the Provider Enrollment Section of the General Information for Providers chapter of the MDHHS Medicaid Provider Manual for additional enrollment information).

### A. CMC TCM Core Team

Required CMC TCM core team members include the following:

- pediatrician;
- non-physician practitioner (NPP);
- registered nurse (RN);
- licensed clinical social workers (LCSW);

- program coordinator;
- administrative staff; and
- beneficiary/parent/guardian

Additional team members may be added to consult regarding specific health concerns (i.e., dietician, respiratory and other therapists, etc.).

Qualifications of individual CMC TCM core team members are as listed:

| | |
|---|---|
| **Pediatrician (Medical Director)** | A Medicaid-enrolled and CSHCS-approved, board certified or board eligible pediatrician currently licensed to practice under Michigan state law and functioning within their scope of practice. Experience and/or training in palliative care recommended. Pediatricians are expected to remain familiar with current developments and standards of treatment in complex care management and to serve as the medical director for the CMC TCM Core Team. |
| **Non-Physician Practitioner (NPP)** | Medicaid-enrolled NPP licensed in the state of Michigan. An NPP is a health care professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist functioning within their scope of practice. Experience and/or training in palliative care recommended. Minimum two years of experience in complex care management with the pediatric population and/or training/experience in pediatric palliative care. |
| **Registered Nurse Clinical Case Manager (RN)** | Licensure as a Registered Nurse by the Michigan Department of Licensing and Regulatory Affairs (LARA) and at least two years of pediatric nursing experience in complex care management with the pediatric population. |
| **Licensed Clinical Social Worker (LCSW)** | Licensure as a fully licensed Clinical Social Worker by LARA and at least two years of experience in counselling and providing services to children with complex medical conditions and their families. |
| **Coordinator** | Individual with a bachelor's degree and a background in health care who is knowledgeable about care coordination services. Responsible for daily operations, as well as collecting evaluation data, administering patient experience surveys, monitoring outcomes, and submitting reports. |
| **Administrative Staff** | Individual with a background in health care operations, including scheduling of both in-person and virtual visits. Interacts with beneficiaries, takes messages, completes required forms and other administrative duties as assigned. |
| **Beneficiary/parent/guardian** | The beneficiary, parent or guardian must be an active, participating team member in the assessment and development/implementation of the beneficiary's comprehensive, individualized plan of care. |

Additionally, the CMC TCM core team is required to have:

- the ability to support full integration of psychosocial and clinical care;
- sufficient documentation that demonstrates staff has adequate knowledge and experience to provide comprehensive and intensive case management services to beneficiaries with complex medical and psychosocial needs;
- referral and/or effective working relationships with key health care and other service providers that are essential to the care of beneficiaries with complex medical and psychosocial needs (e.g., primary care, private duty nurses, specialists and subspecialists, and community and social service organizations);
- all CMC TCM providers must enroll through the online MDHHS Community Health Automated Medicaid Processing System (CHAMPS) Provider Enrollment (PE) subsystem to be reimbursed for fees for services rendered to beneficiaries; and
- all affiliated providers whose services are directly reimbursable per MDHHS policy must be separately enrolled in CHAMPS and must receive a beneficiary-specific authorization from CSHCS (as identified on the CSHCS system) prior to billing for CMC TCM services.

### B. Telemedicine

CMC TCM providers must conduct the initial assessment with the CMC TCM beneficiaries in-person. Subsequently, CMC TCM providers must meet in-person with beneficiaries at a minimum of once per year. Services specified as "face-to-face" per MDHHS telemedicine policy can either be performed in-person or via simultaneous audio/visual telemedicine. CMC TCM providers are required to follow Medicaid telemedicine policy requirements as applicable. (Refer to the Telemedicine chapter of the MDHHS Medicaid Provider Manual.)

## VI. Reporting Requirements

### A. CMC TCM Provider Reporting

To monitor and evaluate the CMC TCM services, MDHHS requires the CMC TCM provider to collect, and report specified information to MDHHS. To the extent possible, MDHHS paid claims data will be utilized for monitoring and evaluation and will only rely on the CMC TCM provider for data not available through the claim system. CMC TCM providers are required to respond to data requests as a condition of continued participation as a CMC TCM site. In addition, CMC TCM providers are required to submit monthly enrollment and beneficiary-staffing reports, as well as annual patient experience surveys specific to CMC TCM services to MDHHS.

i. Monthly Enrollment Report

CMC TCM providers are required to submit a cumulative beneficiary enrollment report to MDHHS monthly.

ii. Beneficiary Staffing Summary Report

CMC TCM providers are required to submit a beneficiary caseload and staffing summary to MDHHS monthly. The beneficiary-staffing report may be submitted with the monthly enrollment report.

iii. Patient Experience Survey

CMC TCM providers are required to conduct a standardized annual patient experience survey of beneficiaries. The purpose of the survey is to obtain feedback from each beneficiary and/or their parent/guardian regarding their satisfaction with the assistance and support received through the CMC TCM services. CMC TCM providers may be required to periodically share the survey results with MDHHS.

CMC TCM providers are required to conduct outreach to beneficiaries/parents/guardians to inform them of the survey, as well as document any action taken to improve services or their approach to care based on feedback received from the patient experience survey.

In addition, CMC TCM providers are required to conduct annually, at a minimum, a set of interviews with at least three beneficiaries and/or their parents/guardians who received CMC TCM services to assess needs unique to the hospital/medical university.

MDHHS may collaborate with the CMC TCM providers to change reporting requirements at any time. Providers may be required to submit additional data to MDHHS upon request. MDHHS will also establish ongoing monitoring activities for the CMC TCM services (i.e., audits, site reviews, etc.) to ensure compliance with MDHHS requirements.

## VII. Claims Submission

Claims must be submitted under the CMC TCM services unique NPI number. Medicaid reimbursement for CMC TCM services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

CMC TCM services are carved out of the MHPs and are billed and reimbursed as a FFS benefit. All providers submitting claims for services must be Medicaid-enrolled. (Refer to the Billing & Reimbursement for Professionals chapter and the Billing & Reimbursement for Institutional Providers chapter of the MDHHS Medicaid Provider Manual for additional billing information.)

### A. Allowable Procedure Codes

All claims submitted for CMC TCM services provided to beneficiaries must include the following Healthcare Common Procedure Coding System (HCPCS) procedure codes:

- **G0506 – Comprehensive assessment and care planning for patients requiring chronic case management services**. This code must be used when billing for activities related to the initial, comprehensive assessment and completion of the comprehensive, individualized plan of care. This code is limited to one unit of service every (rolling) two years, per provider, per beneficiary. This code is not reimbursable for dates of service (DOS) in the same calendar month for the same provider and beneficiary as T2023.

  Providers receive a flat fee per beneficiary for the completion of a comprehensive assessment and comprehensive, individualized plan of care that meets the coverage criteria, including an in-person contact with the CMC TCM core team. These activities are reimbursable only for beneficiaries who meet the CMC TCM services' criteria and requirements. The rate of reimbursement for comprehensive assessment and care planning (G0506) under the CMC TCM program is $1,000.00

- **T2023 – Targeted case management per month**. This code must be used to bill ongoing referral and care coordination services and monitoring and follow-up activities. This code is limited to one unit of service per calendar month, per provider, per beneficiary. This code is not reimbursable for DOS in the same calendar month for the same provider and beneficiary as G0506.

  Ongoing referral and care coordination services and monitoring and follow-up activities are reimbursable for beneficiaries who have a completed comprehensive assessment and comprehensive, individualized plan of care. Periodic reassessments, reviews, and updates of the plan of care are reimbursable as part of the ongoing monitoring and service coordination activities.

  Services are reimbursable only if a member of the CMC Core Team has at least one face-to-face or reciprocal contact with the beneficiary and/or their parent/guardian during the billable month. The rate of reimbursement for targeted case management per month (T2023) under the CMC TCM program is $750.00.

## B. Date of Service

Providers should adhere to the following guidelines when determining the DOS:

- For activities related to the comprehensive assessment and comprehensive, individualized plan of care development (indicated by HCPCS procedure code G0506), the DOS is the date the plan of care is completed.

- For activities related to ongoing referral and coordination services and monitoring and follow-up activities (indicated by HCPCS procedure code T2023), indicate the last date the service was performed in the month as the DOS on the claim form. Note: The actual DOS must be identified when documenting each case management activity in the beneficiary's case record.

### C. Place of Service (POS)

Providers should use a valid place of service (POS) code to indicate the setting in which services were provided. If services occurred in multiple settings, providers may bill using the most frequently occurring POS code.

Note: The actual POS must be indicated when documenting each case management activity in the beneficiary's case record

## VIII. Training Opportunities

MDHHS will maintain an online CMC TCM Provider Handbook, as well as provide training opportunities, to support providers who will be furnishing CMC TCM services to beneficiaries. These materials will assist CMC TCM providers in complying with the requirements of the CMC TCM policy, and to practice in accordance with accepted standards, guidelines, and applicable policies published in the MDHHS Medicaid Provider Manual. A webpage will be established for the posting of the CMC TCM Provider Handbook and detailing future training opportunities.