MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Aimee Khaled

Phone Number:

Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

Targeted Case Management Recuperative care is a transitional program for Medicaid beneficiaries who are experiencing homelessness and discharging from an inpatient hospital admission. Beneficiaries are too ill or frail to return to their living environment, but are not eligible to continue hospital level care, skilled nursing care, or other inpatient Medicaid services. Recuperative care is a short-term program that allows beneficiaries to recover post-hospitalization, receive Medicaid services, access medical care, and supportive services.

Reason for policy (problem being addressed):

To expand access to recuperative care services for Medicaid beneficiaries by creating a Targeted Case Management Recuperative Care program.

Budget implication:

☐ budget neutral
☒ will cost MDHHS $ 5 million ($2.2 million GF), and is 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?

Yes, Provider Enrollment Section, Housing Services Section, and Program Review Division.

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 If Yes, please provide status: ☐ Approved ☒ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☒ Yes ☐ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2422-TCM-RC	**Date:** June 20, 2024

Comments Due: July 25, 2024
Proposed Effective Date: September 1, 2024
Direct Comments To: Aimee Khaled
Address:
E-Mail Address: KhaledA@michigan.gov
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Policy Subject: Targeted Case Management - Recuperative Care

Affected Programs: Medicaid, Healthy Michigan Plan

Distribution: Medicaid, Healthy Michigan Plan, Medicaid Health Plan

Summary: Targeted Case Management Recuperative Care is a transitional program for Medicaid beneficiaries who are experiencing homelessness and discharging from an inpatient hospital admission. Beneficiaries are too ill or frail to return to their living environment, but are not eligible to continue hospital level care, skilled nursing care, or other inpatient Medicaid services. Recuperative care is a short-term program that allows beneficiaries to recover post-hospitalization, receive Medicaid services, access medical care, and supportive services.

Purpose: To expand access to recuperative care services for Medicaid beneficiaries by creating a Targeted Case Management Recuperative Care program

Cost Implications: Appropriated budget for FY24 is $5 million gross, $2.2 million general fund.

Potential Hearings & Appeal Issues: Beneficiaries may appeal denial of prior authorization for services.

State Plan Amendment Required: Yes ☒ **No** ☐ **If yes, date submitted:**	**Public Notice Required: Yes** ☒ **No** ☐ **Submitted date:**
Tribal Notification: Yes ☒ **No** ☐ **- Date:** May 1, 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**

Proposed Policy Draft

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

Distribution: All Providers

Issued: August 1, 2024 (Proposed)

Subject: Targeted Case Management - Recuperative Care

Effective: September 1, 2024 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan

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

The purpose of this bulletin is to establish policy for Michigan Medicaid coverage of Recuperative Care (RC). Effective for dates of services on or after September 1, 2024, RC providers may be reimbursed for eligible services when provided to Medicaid beneficiaries 18 years and older.

I. Background

Targeted Case Management (TCM) - RC is a transitional program for Medicaid beneficiaries meeting eligibility requirements who are experiencing homelessness and discharging from an inpatient hospital admission. Beneficiaries are too ill or frail to return to their living environment, but are not eligible to continue hospital-level care, skilled nursing care, or other inpatient Medicaid services. RC is a short-term program that allows these beneficiaries to recover post-hospitalization, receive case management services, access medical care or other Medicaid services, and receive supportive services.

An RC provider will provide case management, room and board, and coordinate accessing medical care and Medicaid services. RC coverage will not exceed 90 days per hospital discharge.

II. Provider Requirements

The RC provider must be an enrolled Medicaid provider. The RC provider must meet the National Institute for Medical Respite Care (NIMRC) standards for medical respite care programs (https://nimrc.org/standards-for-medical-respite-programs/).

The RC provider must have:

- Private or semi-private rooms for Medicaid beneficiaries;
- Allow 24-hour access to rooms;
- Clean linens for each beneficiary upon admission;
- At least three meals per day must be provided;
- Secure place to store personal belongings;
- Secure medication storage accessible by the beneficiary;
- Appropriate storage for all durable medical equipment (DME);
- On-site access to laundry and shower facilities;
- 24-hour access to staff, and staff on-site who are minimally trained in first aid and basic life support on-site at all times;
- Written policies to allow beneficiary visitors to enter the facility/room;
- Written policies and procedures for life-threatening emergencies; and
- A facility that is compliant with local and state fire safety standards.

III. Provider Enrollment

RC providers seeking reimbursement for their services to Medicaid beneficiaries are required to be Medicaid-enrolled providers. To enroll as a Medicaid provider, an RC provider must obtain a Type 2 (Organization) National Provider Identifier (NPI) and complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS).

Organization CHAMPS enrollment instructions can be found on the MDHHS Provider Enrollment page. RC providers are subject to all relevant policy provisions outlined in the MDHHS Medicaid Provider Manual, including the General Information for Providers Chapter.

The RC provider must meet NIMRC standards for medical respite care programs. The RC provider must complete the Michigan Recuperative Care Provider Attestation Form (BPHASA-XXXX) attesting to meeting these requirements and provide any requested documentation to MDHHS to enroll as an RC provider. RC providers must complete the attestation every three years. RC providers must revalidate every five years. Failure to complete these requirements will result in the RC provider being terminated as a Medicaid RC provider.

IV. Eligible Population

RC is covered for Medicaid-enrolled homeless beneficiaries over 18 years old enrolled in fee-for-service (FFS) Medicaid, Healthy Michigan Plan and Managed Care. Emergency Services Only Medicaid, Plan First, and other limited coverage plans are excluded from coverage for recuperative care.

V. Beneficiary Program Eligibility

To be eligible for RC services, the beneficiary must be homeless and discharging from an inpatient hospital stay. The beneficiary must have a need for ongoing case management and support but is not eligible for continued hospitalization or another inpatient or higher acuity setting (such as a nursing facility).

The beneficiary must meet all the following in order for services to be authorized:

1) The beneficiary must be homeless as defined by Housing and Urban Development, homeless category 1, literally homeless (24 CFR §578.3).

2) Beneficiaries must be discharging from an inpatient hospital admission with an acute condition that can be addressed in less than 90 days.

3) Beneficiaries must be medically stable, independently mobile, and be able to manage and perform their own activities of daily living (ADLs).
   - The beneficiary is able to complete ADLs (such as transfers, bed mobility, eating, toileting, etc.) without physical assistance, cueing, or supervision.
   - If a beneficiary does not meet these requirements, they may be eligible for other Medicaid services (e.g. nursing facility) and should be referred for these services.

4) Beneficiaries must be able to manage medications and DME independently.

5) Beneficiaries must have a need for case management and supportive services.

6) Beneficiaries must be at risk for re-hospitalization or severe complications without the support of RC services.

7) The beneficiary is not eligible for continued hospital admission, skilled nursing facility admission, in-patient psychiatric admission, or other Medicaid inpatient services.

RC is not to supplant skilled nursing admission, behavioral health services or other higher acuity settings for which the beneficiary is eligible.

VI. Prior Authorization

RC services must be authorized by the MDHHS Program Review Division (PRD) prior to the start of services for all beneficiaries.

- FFS Beneficiaries – Prior authorization (PA) must be obtained from PRD for care coordination (G9002) and room & board (S9976).
- Medicaid Health Plan (MHP) Beneficiaries – PA must be obtained from PRD for room & board (S9976).

RC providers must contact the PRD Recuperative Care phone line (# TBD) to complete a telephonic request for PA and receive authorization before the start of services.

RC services are authorized and billed per day. RC coverage will not exceed 90 days per hospital discharge.

RC providers must complete the Recuperative Care Prior Authorization Request Data Form (BPHASA-XXXX) when requesting RC services for Medicaid beneficiaries, prior to requesting PA, and maintain it in the beneficiary's record.

The following documents must be readily accessible for reference by the provider during the telephonic review:

- Completed Recuperative Care Prior Authorization Request Data Form (BPHASA-XXXX);
- Most recent history and physical examination;
- Social work notes/assessment, including status as it relates to ineligibility for nursing facility, in-patient psychiatric or other inpatient Medicaid services;
- Hospital consultation reports;
- Emergency department notes, if applicable;
- Most recent updated plan of care (POC) signed and dated by the ordering/managing physician;
- Most recent signed and dated nursing assessment, including a summary of the beneficiary's current status compared to their baseline status, completed by a registered nurse;
- Physical therapy and/or occupational therapy assessment, including a summary of the beneficiary's current functional status or level of functional independence with ADLs, DME and medication management;
- Hospital discharge plan (completed within two days of the PA request), including anticipated discharge orders for services such as medical follow-up, durable medical equipment/supplies, medications and pharmaceuticals;
- Documentation that the beneficiary is homeless as defined by Housing and Urban Development, homeless category 1, literally homeless (24 CFR §578.3); and
- Anticipated admission date and discharge date from the RC facility.

A. PA Request Determinations

If the RC provider does not provide complete information needed during the telephonic request, no determination will be possible, and the provider must contact the PRD RC phone line at a later date when complete information can be provided.

i. Approval of RC Services

If RC services are approved, the provider will be issued an authorization number and end date at the conclusion of the telephonic request.

The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed.

To ensure payment, the provider must verify beneficiary eligibility monthly at a minimum.

If a beneficiary is re-hospitalized during a PA period, upon discharge, RC services may be resumed with the same RC provider without requiring a new PA. Extension of a PA interrupted by a re-hospitalization will be reviewed and considered on an individual basis. Extension of a PA beyond 90 days will be considered on an individual basis.

ii. Denial of RC Services

If services are denied, the RC provider will be informed of the denial. The beneficiary will be sent a letter notifying them of the denial with an explanation of their appeal rights; the denial letter will be sent to the beneficiary's address on record in CHAMPS; a copy of the letter will be sent to the RC provider.

VII. Discharge from Services

RC providers must ensure either one of the following before discharging a beneficiary from RC services:

- The beneficiary's medical condition has improved.
- The beneficiary is being discharged to another setting that can meet their needs.

Note: The beneficiary may choose to discharge at any time or with no housing option if that is their choice.

VIII. Covered Services

The purpose of TCM RC services is to provide a comprehensive array of case management services that are appropriate to the conditions of the beneficiary, and to provide room and board. At a minimum, TCM-RC services must include:

- An in-person 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 (POC);
- Planning, linking, coordinating, follow-up, and monitoring to assist the beneficiary in gaining access to services;
- Assistance in establishing permanent housing;
- Coordination with the beneficiary's primary care provider (PCP), other providers, and MHP, as applicable; and
- Room and Board.

A. Comprehensive Assessment

The comprehensive initial assessment, and periodic reassessment, must be completed in-person by a qualified case manager. The initial assessment must be completed within two days of admission to the RC provider. In-person reassessment must be completed when there is a significant change in the beneficiary's condition or significant changes within the beneficiary's support network.

The comprehensive assessment must include, but is not limited to:

- Beneficiary's history;
- Identifying beneficiary's needs and completing related documentation;
- Identifying community-based resources the beneficiary currently accesses;
- Gathering information from the beneficiary and other chosen sources, such as family members, medical providers, social workers, to form a complete assessment of the beneficiary;
- Assessment of the beneficiary's current access to a PCP and other health care providers;
- Assessment of the beneficiary's current access to transportation; and
- Assessment of the beneficiary's living arrangement prior to admission.

B. Plan of Care

During or within two calendar days following the in-person initial comprehensive assessment visit, a specific care plan that is based on the information collected through the assessment must be developed. The POC must specify the goals and actions to address the medical, educational, social, and/or other services needed by the beneficiary. The qualified case manager must work with the beneficiary and others chosen by the beneficiary to develop those goals, and to identify a course of action to respond to the assessed needs of the beneficiary.

The POC 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 and training, cultural and spiritual needs, and transportation needs. The POC must be updated when the beneficiary is reassessed or has a significant change in condition. The POC should be shared with the beneficiary's MHP, PCP and Prepaid Inpatient Health Plan (PIHP), as applicable, to the extent permitted under all applicable state and federal laws.

C. Qualified Case Manager

Qualified case managers may provide all components of RC services within their scope of practice. A qualified case manager must meet one of the following criteria:

- 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 or case management services; or
- Licensure as a fully licensed Clinical Social Worker by LARA and at least one year of experience providing social work or case management services.

D. Physician or Non-Physician Practitioner (NPP)

A Medicaid-enrolled physician or NPP licensed by LARA must provide general supervision of the case manager. An NPP is a healthcare professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist.

E. Referrals and Related Activities

The qualified case manager will facilitate and coordinate referral and related activities to assist the beneficiary in obtaining needed services of their choosing. Activities such as scheduling appointments or linking the beneficiary with medical, educational, social, and/or other providers, programs, and services to address identified needs and achieve goals specified in the POC are primary components of TCM services. Referral activities include, but are not limited to, the coordination of the following:

- medical/physical and behavioral healthcare services;
- dental services;
- Substance use disorder (SUD) services;
- transportation services;
- housing support and services;
- nutritional and food services and resources (e.g. diabetes education) and/or coordinating referrals to the Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC) or Food Assistance Program (FAP);
- education resources;
- employment, job training, vocational rehabilitation, or other financial services; and
- any additional social supports and services to assist the beneficiary in obtaining other needed services and assistance.

F. Monitoring and Follow-up Activities

Monitoring and follow-up activities include activities and contacts that are necessary to ensure the POC is implemented and adequately addresses the 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 at least once in the six months following discharge, or as frequently as necessary as determined by the case manager, and may be completed in-person or virtually. Monitoring and follow-up activities should determine whether the following conditions are met:

- Services are being furnished in accordance with the beneficiary's POC; and
- Services in the POC are adequate.

Referrals to appropriate community providers should be made if current services in the POC are not adequate.

IX. Professional Services

Professional services are not covered by RC. Professional services or other Medicaid-covered services must be provided and billed by the appropriately enrolled Medicaid provider.

X. Durable Medical Equipment and Medical Supplies

Durable medical equipment (DME) and medical supplies are not covered by RC. DME and medical supplies must be ordered and provided as if the beneficiary was in their own home. RC providers are required to provide safe storage for all necessary DME and medical supply items.

XI. Coordination of Services

The RC provider must ensure coordination in the delivery of services through an integrated process across all aspects of Medicaid services. Integrated services encompass communication from all physicians and disciplines (e.g., skilled nursing and therapy services) as well as other entities (e.g., Home Health, MI Choice Waiver). The RC provider must also provide ongoing training and education for the beneficiary and caregiver with respect to the care and services identified in the POC, as well as for the safe transfer into or discharge from community services. Throughout the care planning process, it is the responsibility of the RC provider to ensure coordination of care and to avoid duplication of services (e.g., Home Health, MI Choice Waiver).

XII. Billing Requirements

RC claims are submitted by the Medicaid-enrolled RC provider. Claims are submitted on a professional claim format and must include an approved RC Healthcare Common Procedure Coding System (HCPCS) code.

Currently covered RC procedure codes, rates and code descriptions are listed below and will be maintained on the RC fee schedule located on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Special Programs.

RC services are to be billed as follows:

- S9976 (lodging per diem) 1 unit/visit per day
- G9002 (care coordination) 1 unit/visit per day

The PA number listed on the Medicaid Authorization Letter must be recorded on the claim.

XIII. Billed Days of Admission

Day of Admission Medicaid reimburses the day of admission if the beneficiary is in the facility prior to midnight.

Day of Discharge Medicaid does not reimburse the day of discharge.

For TCM, services should be billed based upon the beneficiary's enrollment. If the beneficiary is enrolled into an MHP, then the service is to be billed to the MHP. If the beneficiary is enrolled into Medicaid FFS, then the service should be billed through CHAMPS as an FFS claim.

For room and board, both MHP and FFS enrolled beneficiary claims should be submitted through CHAMPS for Medicaid FFS reimbursement.

PA requirements apply to MHP and FFS claims for TCM services as well as room and board.