

II. Waiver of Proposed Rulemaking and 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive this notice and comment procedure if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

Section 553(d) of the APA ordinarily requires a 30-day delay in effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued.

Therefore, for reasons noted below, we find good cause to waive proposed rulemaking and the 30-day delayed effective date for the corrections in this notice. This notice merely corrects typographical and technical errors in the preamble and regulations text of the September 5, 2007 final rule and does not make substantive changes to the policies that were adopted in the final rule. Therefore, we find that undertaking further notice and comment procedures to incorporate these corrections into the final rule and delaying the effective date of these changes is unnecessary and contrary to the public interest.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance, and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 27, 2007.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 07–5905 Filed 11–30–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 440, and 441

[CMS–2237–IFC]

RIN 0938–AO50

Medicaid Program; Optional State Plan Case Management Services

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period revises current Medicaid regulations to incorporate changes made by section 6052 of the Deficit Reduction Act of 2005. In addition, it incorporates provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Omnibus Budget Reconciliation Act of 1986, the Tax Reform Act of 1986, the Omnibus Budget Reconciliation Act of 1987, and the Technical and Miscellaneous Revenue Act of 1988, concerning case management and targeted case management services. This interim final rule with comment period will provide for optional coverage of case management services or targeted case management services furnished according to section 1905(a)(19) and section 1915(g) of the Social Security Act. This interim final rule with comment period clarifies the situations in which Medicaid will pay for case management activities and also clarifies when payment will not be consistent with proper and efficient operation of the Medicaid program, and is not available.

DATES: *Effective Date:* The effective date of this rule is March 3, 2008.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on February 4, 2008.

ADDRESSES: In commenting, please refer to file code CMS–2237–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to <http://www.cms.hhs.gov/eRulemaking>. Click on the link “Submit electronic comments on CMS regulations with an open comment period.” (Attachments

should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–2237–IFC, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–2237–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Jean Close, (410) 786–5831.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–2237–IFC and the specific “issue identifier” that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.cms.hhs.gov/eRulemaking>. Click on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely also will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

[If you choose to comment on issues in this section, please include the caption "Background" at the beginning of your comments.]

Case management is commonly understood to be an activity that assists individuals in gaining access to necessary care and services appropriate to their needs. Many individuals, because of their age, condition, illness, living arrangement, or other factors, may benefit from receiving direct assistance in gaining access to services. In the context of this regulation, it is the individual's access to care and services that is the subject of this management—not the individual. Because case management has been subject to so many different interpretations over the years, many Medicaid agencies now refer to case management as "care management," "service coordination," "care coordination" or some other term related to planning and coordinating access to health care and other services on behalf of an individual. Because section 1915 of the Social Security Act (the Act) uses the term "case management," we will use this term throughout this document.

In 1981, the Congress amended the Act to authorize Medicaid coverage of case management services under two provisions. Under section 1915(b) of the Act, States were authorized to develop primary care case management systems in order to direct individuals to appropriate Medicaid services. Under section 1915(c) of the Act, States were authorized to furnish case management

as a distinct service under home and community-based services waivers. Case management is widely used under both authorities because of its value in ensuring that individuals receiving Medicaid benefits are assisted in making necessary decisions about the care they need and in locating service providers.

The regulations set forth in this interim final regulation implement in 42 CFR parts 431, 440, and 441 the case management services provisions authorized by sections 1905(a)(19) of the Act and 1915(g) of the Act. The definition of case management in the Deficit Reduction Act was effective on January 1, 2006. The provisions of this rule are effective 90 days after the date of publication of this rule.

II. Legislative History

A. Changes Made by the Consolidated Omnibus Budget Reconciliation Act of 1985

Section 9508 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Pub. L. 99-272), enacted on April 7, 1986, amended the Act concerning the provision of targeted case management services. Specifically, section 9508 of COBRA added a new section 1915(g) to the Act that—

- Provided that a State may elect to furnish case management, targeted to specified groups, as a service covered under the State plan;
- Defined case management services as services that will assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational, and other services;
- Provided an exception to the statewideness requirement of section 1902(a)(1) of the Act by allowing a State to limit its provision of case management services to individuals who reside in particular geographic areas or political subdivisions within the State;
- Provided an exception to the comparability requirement of section 1902(a)(10)(B) of the Act by allowing a State to furnish case management services to any specific group (targeted case management); and
- Required that there be no restriction on free choice of providers of case management services that would violate section 1902(a)(23) of the Act.

B. Changes Made by the Omnibus Budget Reconciliation Act of 1986

Section 9411(b) of the Omnibus Budget Reconciliation Act of 1986 Pub. L. 99-509, enacted on October 21, 1986, amended section 1915(g) of the Act by clarifying that a State may limit the provision of case management services

to individuals with acquired immune deficiency syndrome (AIDS), AIDS-related conditions, or with either. Section 1915(g) of the Act also was amended to clarify that a State may limit case management services to individuals with chronic mental illness.

C. Changes Made by the Tax Reform Act of 1986

Section 1895(c)(3) of the Tax Reform Act of 1986 (Pub. L. 99-514), enacted on October 22, 1986, amended the statute to permit States to furnish non-targeted case management services under a State Medicaid plan. This law amended section 1905(a) of the Act by adding a new paragraph (19) that included case management services, as defined in section 1915(g)(2) of the Act, in the list of optional services a State may include in its Medicaid plan (the existing paragraph (19) was redesignated as paragraph (20)).

D. Changes Made by the Omnibus Budget Reconciliation Act of 1987

Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) Pub. L. 100-203, enacted on December 22, 1987, amended section 1915(g)(1) of the Act to allow States to limit the providers of case management services available for individuals with developmental disabilities or chronic mental illness to ensure that the case managers for those individuals are capable of ensuring that those individuals receive needed services.

E. Changes Made by the Technical and Miscellaneous Revenue Act of 1988

Section 8435 of the Technical and Miscellaneous Revenue Act of 1988 (Pub. L. 100-647), enacted on November 10, 1988, prohibited the Secretary from denying approval of a State plan amendment to provide case management services on the basis that a State is required to provide those services under State law or on the basis that the State had paid or is paying for those services from other non-Federal revenue sources before or after April 7, 1986. This provision also specified that the Secretary was not required to make payment under Medicaid for case management services that are furnished without charge to the users of such services.

F. Changes Made by the Deficit Reduction Act of 2005

Section 6052 of the Deficit Reduction Act (DRA) of 2005 (Pub. L. 109-171), enacted on February 8, 2006, addresses Reforms of Case Management and Targeted Case Management under Medicaid. This section redefined the

term “case management services” to mean services that will “assist individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services” and to include the following components:

- Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. These activities are defined to include the following:

—Taking client history.

—Identifying the needs of the individual, and completing related documentation.

—Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

- Development of a specific care plan based on the information collected through the assessment described above. The care plan specifies the goals of providing case management to the eligible individual and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual’s authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities to help an individual obtain needed services, including activities that help link the eligible individual with medical, social, educational providers, or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

- Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring and follow-up activities may be with the individual, family members, providers, or other entities. These activities may be conducted as frequently as necessary to help determine such matters as:

—Whether services are being furnished in accordance with the individual’s care plan.

—Whether the services in the care plan are adequate to meet the needs of the individual.

—Whether there are changes in the needs or status of the individual.

If there are changes in the needs or status of the individual, monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Section 6052 of the DRA also clarifies that the term “case management” does not include the “direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred” by adding clause section 1915(g)(2)(A)(iii) of the Act. In addition, with respect to foster care, the statute gives examples of some types of activities that are not covered. With respect to the direct delivery of foster care services, the following activities are not considered to qualify as components of Medicaid case management services:

- 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;
- or
- Making placement arrangements.

The DRA also added a new section 1915(g)(2)(B) to the Act, defining the term “targeted case management services” as case management services that are furnished without regard to the requirements of section 1902(a)(1) of the Act, regarding statewide availability of services, and section 1902(a)(10)(B) of the Act, regarding comparability of services. Although the ability to provide these services without regard to section 1902(a)(1) of the Act and section 1902(a)(10)(B) of the Act is not new, this paragraph clarifies that the State can “target” case management services to specific classes of individuals, or to individuals who reside in specified areas of the State (or both).

Section 6052 of the DRA also added a new section 1915(g)(3) to the Act, to clarify that when a case manager contacts individuals who are not eligible for Medicaid, or who are Medicaid eligible but not included in the eligible target population in the State, that contact may qualify as Medicaid case management services. The contact is considered an allowable case management activity when the purpose of the contact is directly related to the management of the eligible individual’s care. It is not considered an allowable case management activity if

those contacts relate directly to the identification and management of the non-eligible or non-targeted individual’s needs and care.

Section 6052 of the DRA added a new section 1915(g)(4) to the Act to discuss the circumstances under which Federal financial participation (FFP) is available for case management or targeted case management services. With a few exceptions described in the following paragraph, in accordance with section 1902(a)(25) of the Act, FFP only is available for the cost of case management or targeted case management services if there are no other third parties liable to pay for those services, including as reimbursement under a medical, social, educational, or other program. When the costs of any part of case management or targeted case management services are reimbursable under another federally funded program, a State is directed to allocate the costs between the other program(s) and Medicaid in accordance with OMB Circular (No. A–87) (or any related or successor guidance or regulations regarding allocation of costs among Federally funded programs) under an approved cost allocation program.

It should be noted that per section 1903(c) of the Act, nothing in this rule would prohibit or restrict payment for medical assistance for covered Medicaid services furnished to a child with a disability because such services are included in the child’s Individualized Education Program (IEP) or Individual Family Service Plan (IFSP). Likewise, payment for those services that are included in the IEP or IFSP would not be available when those services are not covered Medicaid services.

Section 6052 of the DRA also clarified, in a new section 1915(g)(5) of the Act, that nothing in section 1915(g) of the Act shall be construed as affecting the application of rules with respect to third party liability under programs or activities carried out under title XXVI of the Public Health Service Act (the HIV Health Care Services Program) or the Indian Health Service.

This rule implements in Federal regulations the statutory provisions permitting coverage of case management and targeted case management as optional services under a State Medicaid plan, in accordance with sections 1905(a)(19) and 1915(g) of the Act, as amended by the DRA, and all other relevant statutory provisions.

III. Provisions of the Interim Final Rule

[If you choose to comment on issues in this section, please indicate the caption “Provisions of the Interim Final

Rule” at the beginning of your comments.]

To incorporate the policies and implement the statutory provisions described above, we are making the following revisions to 42 CFR chapter IV, subchapter C, Medical Assistance Programs.

A. Freedom of Choice Exception To Permit Limitation of Case Management Providers for Certain Target Groups—§ 431.51(c)

While the freedom of choice requirement is beneficial to the Medicaid population as a whole, in OBRA '87, the Congress recognized that this requirement might not adequately protect the interests of persons with a developmental disability or chronic mental illness. In several States (or political subdivision), a particular agency may be designated under State law or regulation to serve as the exclusive source of case management services with respect to these populations. Therefore, section 4118(i) of OBRA '87 amended section 1915(g)(1) of the Act to provide States with some latitude to restrict the availability of case management providers to these targeted groups to assure that case management providers are capable of ensuring that Medicaid eligible individuals will receive needed services.

Consistent with section 1915(g) of the Act, as amended by section 4118(i) of OBRA '87, when a target group consists solely of individuals with developmental disabilities or chronic mental illness, including a subgroup of those individuals (for example, children with mental illness), States may limit provider participation to specific persons or entities by setting forth qualifying criteria that assure the ability of the case managers to connect individuals with needed services. We note, however, that a State's decision to restrict case managers for these populations does not impinge on targeted individuals' rights to choose freely among those individuals or entities that the State has found qualified and eligible to provide targeted case management services. Absent a waiver to the contrary, those individuals also maintain their right to choose qualified providers of all other Medicaid services they receive.

We are amending § 431.51 by revising paragraphs (c)(2) and (c)(3) and adding a new paragraph (c)(4) to afford States the option of limiting providers of case management services available to furnish services defined in § 440.169 for targeted groups that consist solely of individuals with developmental

disabilities or chronic mental illness. This implements the statutory provisions at section 1915(g)(1) of the Act.

B. Statewide and Comparability Exception to Permitting Targeting—§ 431.54

While a State can provide case management services under its State plan to all Medicaid eligible individuals, it is not required to do so. Under section 1915(g)(1) of the Act, a State is not bound by the “statewide” requirement of section 1902(a)(1) of the Act. (The “statewide” requirement of section 1902(a)(1) of the Act provides, in part, that the provisions of a State plan be in effect in all political subdivisions of the State.) Thus, States may limit the provision of case management services to any defined location of the State (that is, city, county, community, etc.).

Section 1915(g)(1) of the Act also permits States to target case management services to individuals with particular diseases or conditions, without regard to the “comparability” provision in section 1902(a)(10)(B) of the Act. (The “comparability” provision generally requires States to make Medicaid services available in the same amount, duration, and scope to all individuals within the categorically needy group or covered medically needy group. The comparability provision also requires that the Medicaid services available to any individual in a categorically needy group are not less in amount, duration, and scope than those Medicaid services available to an individual in a medically needy group.) Thus, a State may limit case management services to any specific identifiable group, such as individuals with human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), AIDS-related conditions, or chronic mental illness. A State's flexibility to target case management services to a specific group sets these services apart from most other services available under the Medicaid program.

In identifying the groups eligible to receive targeted case management services, States are not required to distinguish eligible individuals by traditional Medicaid concepts of eligibility groups (that is, mandatory categorically needy, optional categorically needy, medically needy), although this avenue continues to be available to States, should they choose it. Instead, States may target case management services by age, type or degree of disability, illness or condition, or any other identifiable characteristic

or combination of characteristics. There is no limit on the number of groups to whom case management services may be targeted.

We note that the exception to the comparability requirement applies only to the provision of targeted case management services under section 1915(g) of the Act. The comparability requirements of section 1902(a)(10)(B) of the Act continue to apply to all other Medicaid services for which an individual may be eligible, unless these services are subject to comparability exceptions in their own right. In other words, receipt of case management services does not in any way alter an individual's eligibility to receive other services under the State plan.

In § 431.54, we are revising paragraph (a) and adding a new paragraph (g) that includes targeted case management services as an exception to the comparability requirements in § 440.250 and to the statewide operation requirement in § 431.50(b). This implements the targeting provisions at section 1915(g)(1) of the Act.

C. Definition of Case Management Services—§ 440.169

Consistent with the provisions of section 1915(g)(2) of the Act, as added by the DRA, we will define case management services in § 440.169(a) generally as services that assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. The intent of case management is to assist the individual in gaining access to needed services, consistent with the requirements of the law and these regulations. “Other services” to which an individual eligible under the plan may gain access may include services such as housing and transportation.

In § 440.169(b), we define targeted case management services as case management services furnished to particular defined target groups or in any defined locations without regard to requirements related to statewide provision of services or comparability.

The integrated medical direction and management of services furnished to inpatients in a medical institution already includes case management activities. Therefore, including separate coverage for institutionalized individuals will in general, result in duplicative coverage and payment. Individuals with complex and chronic medical needs and individuals transitioning to a community setting after a significant period of time in a hospital, nursing facility, or intermediate care facility for individuals with mental retardation, however,

require case management that is beyond the scope of work of institutional discharge planners. These case management services facilitate the process of transitioning individuals from institutional care to community services. For example, individuals may require assistance locating community services. Thus, services we define as case management services for transitioning individuals from medical institutions to the community will be included as a separately covered case management service.

In § 440.169(c), we define case management services for the transitioning of individuals from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions) may be considered to be transitioning to the community during the last 60 consecutive days (or a shorter period specified by the State) of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short-term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. We use these time requirements to distinguish case management services that are not within the scope of discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. As specified in § 441.18(a)(8)(vii)(D) and (E), FFP would not be payable until the date that an individual leaves the institution, is enrolled with the community case management provider, and receiving medically necessary services in a community setting.

In sum, we are defining the case management benefit to include only services to individuals who are residing in a community setting or transitioning to a community setting following an institutional stay.

Our proposed exclusion of FFP for case management services or targeted case management services provided to individuals under age 65 who reside in an IMD or to individuals involuntarily living in the secure custody of law enforcement, judicial, or penal systems is consistent with the statutory requirements in paragraphs (A) and (B) following paragraph section 1905(a)(28) of the Act. The statute indicates that “except as otherwise provided in paragraph (16), such term [medical assistance] does not include (A) any such payments with respect to care or services for any individual who is an

inmate of a public institution. An individual is considered to be living in secure custody if serving time for a criminal offense in, or confined involuntarily to, State or Federal prisons, local jails, detention facilities, or other penal facilities. A facility is a public institution when it is under the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Case management services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State’s Plan, and are not used in the administration of other non-medical programs.

At paragraph (B), following paragraph section 1905(a)(28) of the Act, the statute indicates that medical assistance does not include “any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.” Paragraph (16) includes in the definition of “medical assistance” “* * * inpatient psychiatric hospital services for individuals under age 21 * * *”. Section 1905(h) of the Act defines “inpatient psychiatric hospital services” to include inpatient services in inpatient settings other than psychiatric hospitals, as specified by the Secretary in regulations. The Secretary has specified in regulations at § 440.160 that such settings include “a psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization with comparable standards, that is recognized by the State.” Thus, the term “inpatient hospital services for individuals under age 21” includes services furnished in accredited psychiatric residential treatment facilities, currently known as “PRTFs,” providing inpatient psychiatric services for individuals under age 21 that are not hospitals.

However, the statutory wording of the exception to the IMD exclusion makes it clear that medical assistance includes payment only for *inpatient hospital services* furnished to residents under age 21 in an inpatient psychiatric hospital or, by regulation, to residents under age 21 in an accredited PRTF. FFP does not extend to other services

furnished to individuals under age 21 residing in these settings. However, we are clarifying in this rule that FFP is available for community case management services to transition an individual receiving inpatient psychological services for individuals under age 21 (authorized under section 1905(a)(16) of the Act), after discharge from a medical institution to the community. FFP would not be payable until the date that an individual leaves the institution, is enrolled with the community case management provider, and receiving medically necessary services in a community setting.

At § 440.169(d), we specify that case management includes the following elements specified in section 1915(g)(2)(A)(ii) of the Act:

1. Assessment and periodic reassessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include:

- Taking client history.
- Identifying the needs of the individual and completing related documentation.
- Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

Because the statute defines case management services as those services that will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services, we believe that an assessment of an individual’s needs should be comprehensive and address all needs of the individual. Thus, we are requiring in § 440.169(d)(1) that the assessment be comprehensive in order to address all areas of need, the individual’s strengths and preferences, and consider the individual’s physical and social environment. Performance of a comprehensive assessment can minimize the need for an individual to be covered under multiple case management plans and have multiple case managers, and can reduce the likelihood of service duplication and inefficiencies.

Assessment includes periodic reassessment to determine whether an individual’s needs and/or preferences have changed. At this time, we will not put forth Federal standards for the frequency of reassessment, but recommend that face-to-face reassessments be conducted at least

annually or more frequently if changes occur in an individual's condition.

2. Development and periodic revision of a specific care plan based on the information collected through an assessment or reassessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals and identify a course of action to respond to the assessed needs of the eligible individual.

Because the assessment of an individual's needs must be comprehensive, the care plan also must be comprehensive to address these needs. However, while the assessment and care plan must be comprehensive and address all of the individual's needs, an individual may decline to receive services in the care plan to address these needs. Section 1902(a)(23) of the Act requires that recipients have free choice of qualified providers. This means that the individual cannot be required to receive services from a particular provider—or from any provider—if the individual chooses. If an individual declines services listed in the care plan, this must be documented in the individual's case records.

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

- Referral and related activities do not include providing transportation to the service to which the individual is referred, escorting the individual to the service, or providing child care so that an individual may access the service. The case management referral activity is completed once the referral and linkage has been made. It does not include the direct services, program, or activity to which the individual is linked.

- Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring and follow-up activities may be with the individual, family members, providers, or other entities or individuals. These activities may be conducted as frequently as necessary to help determine whether:

- The services are being furnished in accordance with the individual's care plan.

- The services in the care plan are adequate to meet the needs of the individual.

- There are changes in the needs or status of the individual. If there are changes in the needs or status of the individual, monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring may involve either face-to-face or telephone contact. We are requiring that monitoring occur at a frequency established by the State, but no less frequently than annually.

In the course of providing case management services, case managers can use a person-centered approach. A person-centered approach is a process used to develop, implement, and manage a care plan that attempts to fulfill the objectives and personal preferences of the individual or the legal representative of that individual. The process focuses on the person rather than the system; directly involves the person (or the legal representative of that individual) in the plan development, all aspects of implementation and management; and is tailored to meet individualized needs. Varying levels of person-centered planning, including choice not to participate, may be selected by the individual (or by the individual's legal representative). The individual or legal representative can participate throughout all components of case management and direct who may participate in the care plan development process along with the case manager and the individual or the individual's legal representative.

Case management services must be provided by a single Medicaid case management provider. This provision is consistent with the requirement that the case management includes a comprehensive assessment and care plan. Thus, when an individual could be served under more than one targeted case management plan amendment because he falls within the scope of more than one target group (for example when the individual has both mental retardation and a mental illness and the State has target groups for both conditions), a decision must be made concerning the appropriate target group so that the individual will have one case management provider. That provider will be responsible for ensuring that the comprehensive assessment and care plan address the individual's needs stemming from mental retardation and

from the mental illness. In doing so, the case management provider must coordinate with service providers in both systems of care to ensure that the individual's needs are met. We intend to provide for a delayed compliance date so that States will have a transition period of the lesser of 2 years or 1 year after the close of the first regular session of the State Legislature that begins after this regulation becomes final before we will take enforcement action on the requirement for one case manager to provide comprehensive services to individuals. We will be available to States as needed for technical assistance during this transition period.

We note that section 1915(g)(2) of the Act specifically defines case management services in terms of services furnished to individuals who are eligible under the State plan. This provision reinforces basic program requirements found in section 1905(a) of the Act that require medical assistance to be furnished only to eligible individuals. An "eligible individual" is a person who is eligible for Medicaid and eligible for case management services (including targeted case management services) as defined in the Medicaid State plan, at the time the services are furnished. Case management as medical assistance under the State plan cannot be used to assist an individual, who has not yet been determined eligible for Medicaid, to apply for or obtain this eligibility. (Those activities may be an administrative expense of the State's operation of its Medicaid program, rather than a medical assistance service.)

While the provision of case management services to non-Medicaid eligible individuals cannot be covered, we are including a regulatory provision at § 440.169(e) to make clear that the effective case management of eligible individuals may require some contact with non-eligible individuals. For instance, in completing the assessment for a Medicaid eligible child for whom targeted case management is available, it may be appropriate for a case manager to interview the child's parents and/or other family members who are not eligible for Medicaid, or who are not, themselves, part of a target population specified in the State plan. Contacts with family members that are for the purpose of helping the Medicaid-eligible individual access services can be covered by Medicaid. It also may be appropriate to have non-eligible family members involved in all components of case management because they may be able to help identify needs and supports to assist the eligible individual in

obtaining services, provide case managers with useful feedback, and alert case managers to changes in the individual's needs.

A case manager's contacts with individuals who are not eligible for Medicaid, or who are not included in the group who receives targeted case management services, can be considered allowable activities, eligible for FFP, when the purpose of the contact is directly related to the management of the eligible individual's care. However, these activities will not be considered allowable if they relate directly to the identification and management of the non-eligible, or non-targeted individual's needs and care. Contacts that relate to the case management of non-eligible individuals, that is, assessment of their needs, referring them to service providers, and monitoring their progress, cannot be covered by Medicaid due to the fact they are not Medicaid eligible or not covered under the case management target population. If these other family members or other individuals also are Medicaid eligible and covered under a target group included in the State plan, Medicaid could pay for case management services furnished to them. In addition, these individuals could receive other medically necessary services for which they may qualify.

D. Comparability Exception To Permit Targeting—§ 440.250

We will revise § 440.250 by adding a new paragraph (r) to provide for an exception to the comparability requirements under § 440.240 for targeted case management services.

E. Technical Change to Statement of Statutory Basis—§ 441.10

In part 441, subpart A, we will revise § 441.10 to add a new paragraph (m), which provides a statutory basis for the provision of case management and targeted case management services.

F. Limitations on Case Management Services—§ 441.18

At § 441.18(a)(1), we are specifying that, with the exception discussed above at § 431.51, individuals must have the free choice of any qualified provider. Section 9508 of COBRA amended section 1915(g) of the Act to require that there be no restriction on a recipient's free choice of providers, in violation of section 1902(a)(23) of the Act. Based on COBRA's legislative history, we believe the Congress intended that individuals receiving case management services under section 1915(g) of the Act not be locked into designated providers, whether for case management services,

or for other services. (See H. Rept. No. 453, 99th Cong., 1st Sess. 546 (1985).) Therefore, except as described in § 441.18(b), individuals eligible to receive case management (or targeted case management) services must be free to choose their case management provider from among those that have qualified to participate in Medicaid and are willing to provide the services.

States must establish qualifications for providers of case management services in the State plan. These qualifications relate to minimum age requirements, education, work experience, training, and other requirements, such as licensure or certification, which the State may establish. The Act does not set any minimum educational or professional qualifications for the provision of case management services. Therefore, States have flexibility to establish qualifications that are reasonably related to the demands of the Medicaid case management services to be furnished and the population being served. For example, it is reasonable to expect that the qualifications for case managers serving children who are ventilator-dependent to be different than those qualifications for case managers serving persons with intellectual disabilities. While the case manager must possess the knowledge and skills to conduct a comprehensive assessment and to assist the individual or the individual's legal representative with the development of a comprehensive care plan, this does not mean that the case manager must have experience with the program requirements of every medical, social, educational, or other program to which an individual may be referred; it means that the case manager must be familiar with the general needs of the population being served and must be able to connect and coordinate with medical, social, educational, and other programs that serve the population. If the case manager also provides other services under the plan, the State must ensure that a conflict of interest does not exist that will result in the case manager making self-referrals.

We are also including at § 441.18(a)(2) and § 441.18(a)(3) provisions to ensure that the provision of case management is neither coerced nor a method to restrict access to care or free choice of qualified providers. The receipt of case management services must be at the option of individuals included in a specific target group. This requirement is also consistent with section 1902(a)(19) of the Act. A recipient cannot be compelled to receive case management services for which he or she might be eligible. Requiring an

individual to receive case management services against his or her will would not be in the best interest of the individual and, thus, will violate sections 1902(a)(19) and 1902(a)(23) of the Act. A State also cannot condition receipt of case management services on the receipt of other services since this also serves as a restriction on the individual's access to case management services.

Section 1915(g)(1) of the Act prohibits the use of case management services in any fashion that will restrict an individual's access to other care and services furnished under the State plan, which will violate section 1902(a)(23) of the Act. The purpose of case management services authorized by section 1915(g) of the Act is to help an individual gain access to services, not hinder this access. Permitting case managers to function as gatekeepers under this optional State plan service will allow case managers to restrict access to services—that is, to the extent to which authorization may be denied, access also may be denied. Because this concept is contrary to the statutory definition of case management services, providers of case management services (including targeted case management services) furnished under this section are prohibited from serving as gatekeepers under Medicaid. (States may use a section 1915(b) waiver or primary care case management (PCCM) services under section 1905(a)(25) for this purpose.) Similarly, a State cannot require that an individual receive case management services as a prerequisite for receiving other Medicaid services.

In § 441.18(a)(4), we require that the State's plan provide that case management services will not duplicate payments made to public agencies or private entities under the State plan and other program authorities. In authorizing States to offer case management services, the Congress recognized that there was some potential for duplicate payments. This recognition led to an explicit statement in the legislative history of COBRA that prohibited the duplication of payments. (See H. Rept. No. 453, 99th Cong., 1st Sess. 546 (1985).) The Congress clarified its prohibition on the duplication of funding in section 8435 of the Technical and Miscellaneous Revenue Act of 1988. This provision prohibits the Secretary from denying approval of a case management State plan amendment on the basis that the State is required to provide those services under State law, or on the basis that the State had paid for those services from other non-Federal funds. In other words, the duplication of payment prohibition does

not preclude States from using Medicaid to pay for case management services that previously had been funded solely with State and/or local dollars. The amendment also specifies, however, that the Secretary is not required to make payment under Medicaid for case management services that are furnished without charge to users of the services.

When an individual could be served under more than one targeted case management plan amendment because he falls within the scope of more than one target group, a decision must be made concerning the appropriate target group so that the individual will have one case manager responsible for his services and duplicate payment for the same purpose will not be made.

While FFP would not be available for case management services that duplicates payments made under other program authorities, section 1903(c) of the Act provides an exception for medical assistance for covered Medicaid services, including case management services, furnished to a child with a disability because such services are included in an individualized education program or individualized family service plan.

In section 441.18(a)(5), we would require case management services to be provided on a one-to-one basis to eligible individuals by one case manager. We are including this requirement to implement the provisions of section 1915(g)(2)(A)(ii) that sets forth a unified care planning process for case management to respond to the needs of eligible individuals based on a comprehensive assessment. The statute describes a step-by-step process, each component built upon the previous one, to ensure that the care plan is effectively implemented and adequately addresses all of the assessed needs of the eligible individual. Having one case manager is necessary to ensure accountability and coordination in assisting individuals in gaining access to services to address all components of assessed need. Fragmenting the service would reduce the quality of case management; the point of case management is to address the complexities of coordinated service delivery for individuals with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need.

We are including § 441.18(a)(6) to prohibit providers of case management services from exercising the State Medicaid agency's authority to authorize or deny the provision of other services under the plan. Although a

State Medicaid agency may place great weight on the informed recommendation of a case manager, it must not rely solely on case management recommendations in making decisions about the medical necessity of other Medicaid services that the individual may receive. The decision to authorize the provision of a service must remain with the State Medicaid agency as required by § 431.10(e). Costs related to these activities, such as prior authorization or determination of medical necessity, which are necessary for the proper and efficient administration of the Medicaid State plan, must be claimed as a direct administrative expense by the Medicaid agency and may not be included in the development of a case management rate.

If a State plan provides for case management services (including targeted case management services), the State must require providers to maintain case records that document the information required by § 441.18(a)(7). These case records must document, for each individual receiving case management, the name of the individual; the dates of case management services; the name of the provider agency (if relevant) and person chosen by the individual to provide the case management services; the nature, content, units of case management services received and whether the goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; timelines for providing services and reassessment; and the need for, and occurrences of, coordination with case managers of other programs.

States that opt to furnish case management services must do so by amending their State plans in accordance with § 441.18(a)(8) and § 441.18(a)(9). FFP is not available for case management as a medical assistance service under sections 1905(a)(19) and 1915(g) of the Act in the absence of an approved amendment to the State's Medicaid plan. A State's amendment to its State plan must contain all information necessary for CMS to determine whether the plan can be approved to serve as a basis for FFP. Each amendment must—

- Specify whether case management will be targeted, and if so, define the targeted group (and/or subgroup);
- Identify the geographic area to be served;
- Describe the services to be furnished including types of monitoring;
- Specify the frequency of assessments and monitoring and

provide a justification for the frequencies (given that targeted groups may vary in their need for case management services);

- Specify the qualifications of the service providers;
- Specify the methodology under which case management providers will be paid and rates are calculated;
- Specifies if case management services are being provided to Medicaid-eligible individuals who are in institutions to facilitate transitioning to the community. In this case, the amendment must specify if case management services are being provided to individuals with long-term stays of 180 consecutive days or longer or to individuals with short-term stays of less than 180 consecutive days.

Furthermore, when States choose to provide case management services to individuals in institutions to facilitate transitioning to the community, the State plan must specify the time period or other conditions under which case management may be provided in this manner. The time period that case management is provided in an institution must not exceed an individual's length of stay. In addition, the State plan must specify the case management activities and include an assurance that these activities are coordinated with and do not duplicate institutional discharge planning; include an assurance that the amount, duration, and scope of the case management activities would be documented in an individual's plan of care which includes case management activities prior to and post-discharge, to facilitate a successful transition to community living; specify that case management is only provided by and reimbursed to community case management providers; specify that FFP is only available to community providers and will not be claimed on behalf of an individual until the individual is discharged from the institution and enrolled in community services; and describe the system and process the State will use to monitor providers' compliance with these provisions.

- In addition, if the State plan provides for targeted case management, the State must submit a State plan amendment for each target group that will receive case management services. A separate amendment also must be submitted for each subgroup within a group if any of these elements differ for that subgroup.

While a State has some flexibility to establish the methodology and rates it will use to reimburse providers of case management or targeted case

management services, a State cannot employ a methodology or rate that results in payment for a bundle of services. Per diem rates, weekly rates, and monthly rates represent a bundled payment methodology that is not consistent with section 1902(a)(30)(A) of the Act, which requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. A bundled payment methodology exists when a State pays a single rate for more than one service furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or otherwise available rates. Since these bundled (daily, weekly, or monthly) rates are not reflective of the actual types or numbers of services provided or the actual costs of providing the services, they are not accurate or reasonable payments and may result in higher payments than would be made on a fee-for-service basis for each individual service. A bundled rate is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for-service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures. We therefore expect that case management and targeted case management services reimbursed on a fee-for-service basis, as opposed to a capitated basis, will be reimbursed based on units of time. Because of the nature of case management, which can include contacts of brief duration, we believe that the most efficient and economical unit of service is a unit of 15 minutes or less. Accordingly, we are requiring in § 441.18(a)(8)(vi) that the unit of service for case management and targeted case management services be 15 minutes or less.

In § 441.18(b) we require that, if a State limits qualified providers of case management services for target groups with developmental disability or chronic mental illness, in accordance with § 431.51(a)(4), the plan must identify the limitations being imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.

At § 441.18(c)(1), we specify that the case management benefit does not include, and FFP is not available for, activities that are an integral component of another covered Medicaid service. To include those activities as a separate benefit will result in duplicate coverage and payment. This activity would not be consistent with proper and efficient

operation of the program. For example, when an individual receives services from a physician and the physician refers the individual to a home health agency for services, that referral is integral to the physician's service and FFP will not be available for that activity as a case management service.

Individuals participating in a managed care plan receive case management services as an integral part of the managed care services. This case management is for the purpose of managing the medical services provided by or through the plan and does not extend to helping an individual gain access to social, educational, and other services the individual may need. Thus, an individual receiving services through a managed care plan may also receive case management or targeted case management services when the individual is eligible for those services. For example, an individual with AIDS served by a managed care plan may also be served under a case management plan targeted to persons with AIDS/HIV. However, FFP is not available for case management of medical services that are also managed by the individual's managed care plan. In this situation, it is expected that the Medicaid case manager would coordinate with the managed care plan as appropriate. At § 441.18(c)(2) through § 441.18(c)(5), we set forth limitations authorized by the DRA on the case management benefit. The regulation text at § 441.18(c) includes the statutory principle set forth at section 1915(g)(2)(A)(iii) of the Act providing that the case management benefit does not include services that involve the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred.

The statutory definition of case management established by the DRA draws a distinction between services that assist an individual in accessing needed services and the actual services to which access is gained. Case management services include only those activities that help an individual gain access to needed medical, social, educational, and other services. Case managers can assist individuals in gaining access to needed services, regardless of the funding source of the service to which the individual is referred. By including more than medical care, States can implement a holistic approach to the delivery of services by using case management to identify all of an individual's care needs and coordinate access to services that address these needs.

Case management does not include the actual direct services the individual

obtains. For this reason, if a case manager provides a direct service, such as counseling, during the course of a case management visit, the direct service cannot be reimbursed as part of the case management service. This service may be covered under another Medicaid service category, such as rehabilitation services, if the service is covered under the State's Medicaid program, the case management provider also is a qualified provider of that service, and the individual chooses to receive the service from the case manager. The performance of diagnostic tests also is a direct service. While diagnostic tests may provide information that inform the assessment and care development process, they do not constitute an assessment activity under section 1915(g)(2) of the Act that is covered under the case management benefit. These services, however, may be covered under another medical assistance category if provided in the State plan. Similarly, referral and related activities do not include the provision of transportation or escort services, nor do they include the provision of day care services so that an eligible individual with children can access needed services. These are direct services rather than coverable case management activities.

The nature of the case management benefit to "assist eligible individuals to gain access to needed services" and the similarity of its 1985 definition to the purpose of other programs also has led many to confuse the Medicaid benefit with the actual administration of non-Medicaid programs. This is particularly true when a large number or percentage of the participants in these non-Medicaid programs also are eligible for Medicaid (and thus, potentially included in a target group eligible to receive targeted case management services). Concerns in this area have been raised through audits, the review of State plan amendments and by the Government Accountability Office (Report GAO-05-748, entitled "States Use of Contingency Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight," June 2005). The following are examples of targeted case management State plans that were inconsistent with Federal policy, resulting in excessive Federal Medicaid outlays. These examples illustrate the need for the specific definitions and guidance contained in this rule.

- In one State, in fiscal year 2003, the State received an estimated \$17 million in Federal reimbursement for targeted case management claims from juvenile justice and child welfare agencies of

which about \$12 million was for services that were integral to non-Medicaid programs.

- A State agency claimed \$86.6 million Federal share in fiscal years 2002 and 2003 for unallowable targeted case management services furnished by a social services agency. Contrary to Federal requirements, the rates charged to Medicaid included social workers' salary costs for child protection and welfare services.

- In a CMS audit of a State's counties that provided targeted case management services, 72 percent of encounters in one county were incorrectly claimed during a 1-year period. These encounters either did not meet the definition of targeted case management at section 1915(g)(2) of the Act or were claimed for clients that were ineligible for Medicaid.

These past abuses and other occurrences of cost shifting from State foster care programs led to the reforms in case management and targeted case management made by section 6052 of the DRA. In the DRA, the Congress specifically precluded the use of the Medicaid case management benefit for the direct delivery of an underlying medical, social, educational, or other service funded by other programs. In addition, the Congress provided examples with respect to foster care of services that are excluded from case management services. The inclusion of examples for foster care does not limit the general prohibition on including the direct services of other programs from case management services under Medicaid as well. For example, the exclusion extends to—

- **Child Welfare/Child Protective Services.** States provide child protective services to children at risk of abuse or neglect. These services include investigation of allegations of abuse or neglect, identification of risk factors, provision of services to children and families in their own homes, monitoring of at-risk children, placement of children into foster care or adoptive homes, and evaluation of interventions. Child protective services includes development and oversight of a service plan for the child and family with the goal of moving the child toward permanency either through family reunification, adoption, or other permanent living arrangement. Because these services have their own goals—protecting vulnerable children and moving them toward a safe and stable living situation—we believe child protective services are the direct services of State child welfare programs and are not Medicaid case management. These activities of child welfare/child

protective services are separate and apart from the Medicaid program. Thus, Medicaid case management services must not be used to fund the services of State child welfare/child protective services workers. Further, Medicaid may not pay for case management services furnished by contractors to the State child welfare/child protective services agency, even if they would otherwise be qualified Medicaid providers, because they are furnishing direct services of the programs of that agency. However, children receiving child welfare/child protective services may still qualify to receive Medicaid targeted case management services, when these services are provided according to the Medicaid State plan program by a qualified Medicaid provider who is not furnishing direct services of other programs. For example, a Medicaid eligible child with a mental disorder receiving child protective services may also qualify to receive case management services targeted to children with mental disorders.

- **Parole and Probation.** States often use parole and probation as methods by which offenders can be eased back into the mainstream society. The supervision, counseling, and oversight required by these programs assist individuals in learning—or re-learning—how to live within the legal bounds that society places on the behavior of its members. Both parole and probation are, however, functions of the administration of the justice system, and exist independent of the Medicaid program. These functions have their own goals (for example, conformance to law, adherence to conditions imposed by a court) which may coincide with goals of the Medicaid program, but exist separate and independent from it. Because probation and parole functions are necessary and integral components of the administration of another system, we believe that parole and probation functions are the direct services of corrections programs and are not Medicaid case management. Thus, we are prohibiting the use of parole or probation officers (or other employees or contractors of the justice system or court) as case management providers under Medicaid. Individuals who are on parole or probation may still qualify to receive Medicaid case management or targeted case management services for which they otherwise qualify (for example, a Medicaid-eligible individual with a traumatic brain injury could qualify to receive case management targeted to a group of persons with brain injuries). However, claims for Medicaid case management must not include the

administration of the State's parole or probation system.

- **Public Guardianship.** Persons who have been determined to need guardians, because they are found incapable of handling their own affairs, may qualify for Medicaid case management when they are also part of a group to whom this service is provided (for example, persons with developmental disabilities). The public guardianship function, however, is also a State or locally administered activity that is independent of the Medicaid program. There is a fundamental difference between guardians (or conservators, or other similarly appointed individuals) and case managers. Case managers may assist decision-makers in reaching conclusions about the needs of an individual and the services that may best meet those needs, but they do not make these decisions on behalf of that individual. That is the function of a guardian (or conservator, or other similarly appointed individual). Case managers may, therefore, assist guardians and others, in enabling an individual to gain access to needed services, but they may not be used to replace or fund the function of this fundamentally non-Medicaid activity.

- **Special Education.** The Individuals with Disabilities Education Act (IDEA) ensures every child with a disability has available a free appropriate public education (FAPE) that includes special education and related services. Part B of the IDEA requires the development and implementation of an individualized education program (IEP) that addresses the unique needs of each child aged 3 through 21 with a disability. Part C of the IDEA requires the development and implementation of an individualized family service plan (IFSP) to address the unique developmental needs of an infant or toddler under 3 years of age with a disability. The IEP identifies the special education and related services needed for the child with a disability. An IFSP identifies the early intervention services and other services needed for an infant or toddler with a disability and his or her family.

While some of the services identified on a child's IEP (e.g., a related service such as physical therapy) may be covered under Medicaid, the development, review, and implementation of the IEP is part of a process that is required by Part B of the IDEA. This process should not be confused with Medicaid case management (or targeted case management) services, which also may be needed by the child. Similarly, under Part C, the IFSP may identify a need for

case management as well as other services and activities some of which may be covered under Medicaid and others that, while a necessary component of the Part C program, are not covered under Medicaid. One distinction between the IEP and IFSP is that the IFSP process for an infant or toddler with a disability under the age of three requires a service coordinator from the outset, some of whose activities may be Medicaid-funded case management (or targeted case management) services. Case management activities in this context could include taking the infant or toddler's history, identifying service needs, and gathering information from other sources to form a comprehensive assessment. Case management would not include administrative functions that are purely IDEA functions such as scheduling IFSP team meetings, and providing the requisite prior written notice.

An IEP or IFSP may identify the need for case management to coordinate access to a broad range of medical service providers from several disciplines, and also may identify needs for case management to gain access to non-medical services. As with other Medicaid covered services (such as physical, occupational, or speech therapy) identified on the IEP or IFSP, such case management services may be covered under Medicaid when furnished to a Medicaid-eligible child by a Medicaid qualified provider who assists in gaining access to and coordinating all needed services. To facilitate coordinated care, case management is a covered Medicaid service only when a single case manager comprehensively addresses all of the individual's service needs.

- While Medicaid funding could be available for the costs of a Medicaid-qualified case manager who may be operating in a school or early intervention program in assisting IDEA-eligible children in gaining access to needed services, including those identified in their IEP or IFSP, coordinating the provision of those services, and facilitating the timely delivery of services, Medicaid case management services must remain separate and apart from the administration of the IDEA programs. Medicaid may pay for those case management services where IDEA and Medicaid overlap, but not for administrative activities that are required by IDEA but not needed to assist individuals in gaining access to needed services. These would include activities such as writing an IEP or IFSP, providing required notices to parents,

preparing for or conducting IEP or IFSP meetings, or scheduling or attending IEP or IFSP meetings. Section 504 of the Rehabilitation Act (RA) of 1973 requires school districts to provide to students with disabilities, appropriate educational services designed to meet the individual needs of such students to the same extent as the needs of students without disabilities are met; that is, to provide an equal opportunity for students with disabilities to participate in or benefit from educational aids, benefits, or services. We are clarifying in this regulation that FFP is not available for any case management activities not included in an IEP or IFSP but performed solely based on obligations under section 504 of the RA to ensure equal access to the educational program or activity.

In accordance with section 1903(c) of the Act, nothing in this rule would prohibit or restrict payment for medical assistance for covered Medicaid services furnished to a child with a disability because such services are included in the child's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP). Likewise, payment for those services that are included in the IEP or IFSP would not be available when those services are not covered Medicaid services. In addition, Medicaid funds must not be used to replace or otherwise supplant funds used for activities related to the administration of the IDEA for infants and young children such as Child Find.

Therefore, at § 441.18(c)(2), we state the general prohibition established by the DRA in section 1915(g)(2)(A)(iii) of the Act on including as Medicaid case management the direct delivery of services, as well as include a list of programs to which we are applying this prohibition in this regulation (parole and probation, public guardianship, special education, child welfare/child protective services, and foster care). We also include in § 441.18(c)(3) the specific statutory examples with respect to foster care—

- 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;
- or

- Making placement arrangements.

These examples of direct delivery of foster care activities are all administrative activities that are integral to the delivery of services through the

foster care program. For the reasons discussed above, since the statute cites these administrative activities as examples, rather than as an all-inclusive list, at § 441.18(c)(3), we are interpreting the exclusion of administrative activities to extend to all administrative activities integral to the administration of the foster care program. Other foster care activities subject to this payment exclusion include case management; referral to services; overseeing foster care placements; the training, supervision, and compensation of foster care parents; and attendance at court appearances related to foster care. Since the activities of foster care programs are separate and apart from the Medicaid program, Medicaid case management services must not be used to fund the services of foster care workers. The following is an example of how this payment exclusion will be applied: When a title IV-E eligible child in foster care is referred by a caseworker to the Medicaid program for medical services or mental health services covered by the Medicaid program, that administrative activity neither can be allocated and claimed to the Medicaid program as an administrative expense of the Medicaid program nor can those costs be claimed as a case management medical assistance service. The State may, instead, claim these costs under the title IV-E program to the extent allowable (see 45 CFR 1356.60(c)(2) and ACF Child Welfare Policy Manual Section 8.1B). FFP for the medical services to which a Medicaid-eligible child who resides in foster care was referred would be available under the Medicaid program.

Furthermore, case management activities included under therapeutic foster care programs will be subject to this payment exclusion since these activities are inherent to the foster care program. FFP for medical services to a Medicaid eligible child with medical care needs who resides in therapeutic foster care would still be available, provided all Medicaid requirements were met.

At § 441.18(c)(4), we also apply this exclusion from the definition of case management the administrative activities integral to other non-medical programs, based on the general exclusion from case management of services delivered under other programs in section 1915(g)(2)(A)(iii) of the Act.

At § 441.18(c)(4), we, thus, will exclude from the case management benefit the administrative activities of any other non-medical program, specifically including activities that constitute the administration of special education programs under IDEA, the

parole and probation functions conducted by or under the authority of State or local courts or other justice entities, legal services provided by any entity, child welfare/child protective services and activities concerning guardianship of a person or the person's assets performed by or under the auspices of offices of public guardianship, or activities by any individual who has been appointed to perform guardianship, conservatorship (or other similar duties) on behalf of a Medicaid recipient by a court.

It is important to note that the exclusion of Medicaid funding for case management activities that are used in the administration of other non-medical programs does not, in any way, compromise Medicaid recipients' eligibility for medically necessary services under the plan, including medically necessary case management (and targeted case management) services that are not used to administer other programs. Thus, a Medicaid eligible child with a developmental disability, who receives foster care services, will qualify for Medicaid case management services targeted towards individuals with intellectual or other developmental disabilities that are not furnished through the foster care program. Similarly, a Medicaid-eligible child with chronic asthma receiving foster care services will receive medically necessary treatment services for that condition funded by Medicaid. Both of these children, who also receive foster care services, will continue to qualify for Medicaid-funded services. Thus, FFP will be available under the Medicaid program for medically necessary services. Similarly, an adult who tests positive for the human immunodeficiency virus (HIV) and is also on parole may continue to be eligible for medically necessary case management services targeted to individuals with HIV that are not furnished through a non-medical State program or for medically necessary treatment services.

In § 441.18(c)(5)), we clarify that activities that meet the definition in § 440.169 for case management services and under the approved State plan cannot be claimed as administrative activities, under § 433.15(b).

Certain activities may be properly claimed as administrative costs when the activities are directly related to the proper and efficient administration of the Medicaid State plan. Sometimes these activities are commonly referred to, by States and others, as "administrative case management"; although, statute and regulation do not include such terminology. These

administrative activities are performed by State agency staff and may involve facilitating access to and coordinating Medicaid program services. Some examples of these administrative activities include Medicaid eligibility determinations and re-determinations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; prior authorization for Medicaid services; utilization review; and Medicaid outreach. These examples are not meant to be all-inclusive and CMS may make determinations regarding whether these or other activities are necessary for the proper and efficient administration of the State plan.

A State may not claim costs for administrative activities for the proper and efficient administration of the State plan if the activities are an integral part or extension of a direct medical service. In addition, unlike case management claimed as a service cost which can extend to coordinating with programs outside of Medicaid, administrative activities are strictly related to enhancing access to Medicaid services.

States may not claim, as administrative activities, the costs related to general public health initiatives, overhead costs, or operating costs of an agency whose purpose is other than the administration of the Medicaid program. Activities directed toward services not included under the Medicaid program, although these services may be valuable to Medicaid beneficiaries, are not necessary for the administration of the Medicaid program, and therefore are not allowable administrative costs. In addition, with regard to any allowable administrative claims, payment may only be made for the percentage of time spent which is actually attributable to Medicaid eligible individuals.

The allocation methodology for costs claimed for the proper and efficient administration of the State plan must be specified in the State's approved public assistance cost allocation plan in accordance with subpart E of 45 CFR part 95 and ASMB C-10.

When the costs of any part of case management or targeted case management are reimbursable under another federally funded program, a State is directed by section 1915(g)(4)(B) of the Act to allocate costs which are reimbursable under the other Federal program in accordance with OMB Circular No. A-87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program. (OMB Circular No. A-87, which details the cost principles for State, local, and

Indian Tribal Governments for the administration of Federal awards, pertains to all Federal agencies whose programs, including Medicaid, are administered by a State public assistance agency.) This requirement is set forth in § 441.18(d). OMB Circular A-87, Attachment A, paragraph C.3.a requires allocation of costs among benefiting cost objectives (programs).

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Waiver of Proposed Rulemaking

Ordinarily, we will publish a notice of proposed rulemaking and afford a period for public comments in accordance with the provisions of the Administrative Procedure Act, 5 U.S.C. 553. Further, we generally provide for final rules to be effective no sooner than 30 days after the date of publication unless we find good cause to waive the delay. Section 6052(b) of the DRA authorizes the Secretary to promulgate regulations to carry out the new statutory provisions at section 1915(g)(2) of the Act "which may be effective and final immediately on an interim basis as of the date of the interim final regulation." In light of the importance of clarifying the definition of case management and ensuring the fiscal integrity of the Medicaid program, we have elected to use this authority to issue this rule as an interim final rule with comment period. Section 6052(b) of the DRA further provides that there must be a period for receipt of public comments after the date of publication of an interim final rule, and that the Secretary may revise the regulation after completion of the period of public comment. We are complying with this requirement to provide for a period of public comment.

This rule has been determined to be a major rule as defined in the Congressional Review Act, 5 U.S.C. § 804(2). These regulations are effective March 3, 2008.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment

before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

Section 440.169 Case Management Services

Section 440.169(d) states that case managers assist eligible individuals by providing services such as taking client history; identifying the needs of the individual, and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual. The case manager must then develop a specific care plan based on the information collected through the assessment.

The burden associated with this requirement is the time and effort put forth by the case manager to gather the information and develop a specific care plan. While this requirement is subject to the PRA, we believe this requirement meets the requirements of 5 CFR 1320.3(b)(2), and as such, the burden associated with this requirement is exempt from the PRA.

Section 441.18 Case Management Services

Section 441.18(a) requires that if a State plan provides for case management services, as defined in § 440.169, the State must require providers to maintain case records that document for all individuals receiving case management the name of the individual; the date of the case management service; the name of the provider agency and the person providing the case management service; and the nature, content, and units of case management service. Details of

what the case records must include are located at § 441.18(a)(7).

The burden associated with this requirement is the time and effort required for a provider to maintain case records. While this requirement is subject to the PRA, we believe this requirement meets the requirements of 5 CFR 1320.3(b)(2), and as such, the burden associated with this requirement is exempt from the PRA.

If you comment on these information collection and record keeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn.: Melissa Musotto, CMS-2237-IFC, Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-1850.
Office of Information and Regulatory Affairs, Office of Management and Budget, Attn.: Katherine Astrich, CMS Desk Officer, CMS-2237-IFC, *katherine_astrich@omb.eop.gov*. Fax (202) 395-6974.

VII. Regulatory Impact Analysis

[If you choose to comment on issues in this section, please indicate the caption "Regulatory Impact" at the beginning of your comments.]

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year).

Section 804(2) of title 5, United States Code (as added by section 251 of Pub. L. 104-121), specifies that a "major rule" is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of \$100 million or more;
- A major increase in costs or prices for consumers, individual industries,

Federal, State, or local government agencies, or geographic regions; or

- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States based enterprises to compete with foreign based enterprises in domestic and export markets.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 million to \$29 million in any 1 year. This rule affects only States directly. For purposes of the RFA, we do not consider States or individuals to be small entities. Therefore, the Secretary certifies that this rule will not have a significant economic impact on a substantial number of small entities.

Section 1915(g) of the Act provides for Medicaid coverage of a new optional State plan service, case management services, and permits those services to be targeted. This regulation incorporates that statutory provision in the Federal regulations.

Under section 1915(g) of the Act, States may, without securing a waiver, furnish case management services, or targeted case management services to specified Medicaid groups on a statewide basis or in a particular geographic area of the State by requesting approval of a State plan amendment. If a State elects to furnish case management services (or targeted case management services), FFP will be available to the State to assist individuals receiving Medicaid in gaining access to needed medical, social, educational, and other services. Thus, the Medicaid case management service adds value to services that would otherwise be received through Medicaid and other programs in the absence of Medicaid case management services. For example, case management services provided to women with a high risk pregnancy can prevent low birth weight infants and case management of chronic problems can reduce hospital emergency room visits. Individuals retain the right to select among qualified medical providers of case management (or targeted case management) services.

Ambiguity concerning what services are reimbursable as case management and targeted case management services has resulted in questionable cost shifting of services onto Medicaid, which increases costs. Although the Medicaid program will continue to pay

for case management and targeted case management services, this regulation clarifies and conforms to current statutory requirements of the regulatory definition. In fiscal year 2006, Federal

and State expenditures for targeted case management services were \$2,842 million. Table 1 contains the Federal and State expenditures for targeted case management. These amounts do not

reflect changes that may have occurred in other services during the projection period as a result of the provision of case management services.

TABLE 1.—MEDICAID TARGETED CASE MANAGEMENT SPENDING

	2001	2002	2003	2004	2005	2006
Federal	1,176	1,384	1,641	1,628	1,620	1,643
State	837	1,020	1,118	1,092	1,185	1,199
Total	2,012	2,405	2,759	2,720	2,805	2,842

Source: CMS-64 Data
Data is reported by Federal fiscal year
All amounts in millions of dollars

Section 6052 of DRA 2005 specifies that FFP is only available for case management services or targeted case management services if there are no other third parties liable to pay for those services, including as reimbursement under a medical, social, educational, or other program. Due to this regulation, it is estimated that Federal Medicaid spending on case management and targeted case management services will be reduced by \$1,280 million between FY 2008 and FY 2012. This reduction in spending is expected to occur as case management services spending that could be paid for by other third parties or other Federal programs, but received by the States as FFP, will no longer be reimbursable.

Due to this regulation, the Assistant Secretary for Resources and Technology estimates that Federal spending on title IV-E foster care services will increase by \$369 million between FY 2008 and FY 2012. This increase is expected to occur because State foster care program expenditures on case management will no longer be reimbursed as Medicaid expenditures and would instead need to be paid by other Federal programs or payment sources.

We are unable to estimate additional net costs/savings that might result from case management under section 1915(g) of the Act for the following reasons. The use of case management services may result in increased access to other services, including those covered under Medicaid. Conversely, provision of case management services may work to lower both Federal and State costs by encouraging the use of cost-effective medical care through transitioning individuals out of institutions, referrals to qualified providers, and by discouraging inappropriate utilization of costly services such as emergency room care for routine procedures. The use of

case management services also may eliminate unnecessary care and over-utilization of services. Further, by facilitating early treatment, the use of case management services can preclude the need for more costly “last resort” treatment alternatives.

Because it is estimated that Federal Medicaid spending on case management and targeted case management services will be reduced by \$1,280 million between FY 2008 and FY 2012 (and thus the annual effect on the economy is \$100 million or more), we have determined that this interim final rule with comment period is a major rule under Executive Order 12866. The Secretary certifies that this rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Core-Based Statistical Area and has fewer than 100 beds. We have determined that this interim final rule with comment period will not have a significant effect on the operations of a substantial number of small rural hospitals because there will be no change in the administration of the provisions related to small rural hospitals. Therefore, the Secretary certifies that this rule will not have a significant impact on small rural hospitals and, accordingly, we are not preparing an analysis for section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated

costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$120 million. This interim final rule with comment period has no consequential effect on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in table 2, we have prepared an accounting statement showing the classification of the savings associated with the provisions of this interim final rule with comment period. Tables 2 and 3 provide our best estimate of the savings to the Federal Government as a result of the changes presented in this interim final rule with comment period based on the estimate in the President’s FY 2008 Budget that Federal Medicaid spending on case management and targeted case management services will be reduced by approximately \$210 million in FY 2008 and will be reduced by \$1,280 million between FY 2008 and FY 2012. All savings are classified as transfers from the State Government to Federal Government.

TABLE 2.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED SAVINGS, FROM FY 2008 TO FY 2012 (IN MILLIONS)

Category	Primary estimates	Year dollar	Units discount rate (percent)	Period covered
Federal Annualized Monetized (millions/year)	\$252.6	2008	7	2008–2012
	254.5	.....	.....	.....
	.....	2008	.....	2008–2012
	256.0	.....	.....	.....
.....	.....	2008	0	2008–2012
From Whom to Whom?	State Government to Federal Government			

TABLE 3.—ANNUAL DISCOUNTED TRANSFERS—CASE MANAGEMENT RULE (IN MILLIONS)

Discount rate (percent)	2008	2009	2010	2011	2012	Total
0	210	230	250	280	310	1,280
3	204	217	229	249	267	1,166
7	196	201	204	214	221	1,036

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 440

Grant programs-health, Medicaid.

42 CFR Part 441

Family planning, Grant programs-health, Infants and children, Medicaid, Penalties, Prescription drugs, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV, subchapter C as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 2. Section 431.51 is amended by—

■ A. Republishing the introductory text to paragraph (c).

■ B. Removing the colon and the word “or” at the end of paragraph (c)(2) and adding a semicolon and the word “or” in its place.

■ C. Removing the period at the end of paragraph (c)(3) and adding in its place a semicolon and the word “or”.

■ D. Adding a new paragraph (c)(4).

The revisions read as follows:

§ 431.51 Free choice of providers.

* * * * *

(c) *Exceptions.* Paragraph (b) of this section does not prohibit the agency from—

* * * * *

(4) Limiting the providers who are available to furnish targeted case management services defined in § 440.169 of this chapter to target groups that consist solely of individuals with developmental disabilities or with chronic mental illness. This limitation may only be permitted so that the providers of case management services for eligible individuals with developmental disabilities or with chronic mental illness are capable of ensuring that those individuals receive needed services.

* * * * *

■ 3. Section 431.54 is amended by—

■ A. Revising paragraph (a).

■ B. Adding a new paragraph (g).

The revision and addition read as follows:

§ 431.54 Exceptions to certain State plan requirements.

(a) *Statutory basis*—(1) Section 1915(a) of the Act provides that a State shall not be deemed to be out of compliance with the requirements of sections 1902(a)(1), (10), or (23) of the Act solely because it has elected any of the exceptions set forth in paragraphs (b) and (d) through (f) of this section.

(2) Section 1915(g) of the Act provides that a State may provide, as medical assistance, targeted case management services under the plan without regard to the requirements of sections 1902(a)(1) and 1902(a)(10)(B) of the Act.

* * * * *

(g) *Targeted case management services.* The requirements of § 431.50(b) relating to the statewide operation of a State plan and § 440.240 of this chapter related to comparability of services do not apply with respect to targeted case management services defined in § 440.169 of this chapter.

PART 440—SERVICES: GENERAL PROVISIONS

■ 6. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 7. A new § 440.169 is added to subpart A to read as follows:

§ 440.169 Case management services.

(a) *Case management services* means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with § 441.18 of this chapter.

(b) *Targeted case management services* means case management services furnished without regard to the requirements of § 431.50(b) of this chapter (related to statewide provision of services) and § 440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.

(c) For purposes of case management services, individuals (except individuals between ages 22 and 64 in an IMD or

individuals who are inmates of public institutions) may be considered to be transitioning to a community setting during the last 60 consecutive days (or a shorter time period as specified by the State) of a covered long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short-term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to a community setting during the last 14 days prior to discharge.

(d) The assistance that case managers provide in assisting eligible individuals obtain services includes—

(1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:

(i) Taking client history.

(ii) Identifying the needs of the individual, and completing related documentation.

(iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.

(2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

(i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.

(ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.

(iii) Identifies a course of action to respond to the assessed needs of the eligible individual.

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

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or

other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

(i) Services are being furnished in accordance with the individual's care plan.

(ii) Services in the care plan are adequate.

(iii) There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

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

§ 440.250 [Amended]

■ 8. Section 440.250 is amended by—

■ A. Adding and reserving paragraph (q).

■ B. Adding a new paragraph (r).

The addition reads as follows:

§ 440.250 Limits on comparability of services.

* * * * *

(q) [Reserved]

(r) If specified in the plan, targeted case management services may be limited to the following:

(1) Certain geographic areas within a State, without regard to the statewide requirements in § 431.50 of this chapter.

(2) Targeted groups specified by the State.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

■ 9. The authority citation for part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 2. Section 441.10 is amended by adding a new paragraph (m) to read as follows:

§ 441.10 Basis.

* * * * *

(m) Section 1905(a)(19) and 1915(g) of the Act for case management services as set forth in § 441.18 and section 8435 of the Technical and Miscellaneous Revenue Act of 1988.

■ 10. A new § 441.18 is added to subpart A to read as follows:

§ 441.18 Case management services.

(a) If a State plan provides for case management services (including targeted case management services), as defined in § 440.169 of this chapter, the State must meet the following requirements:

(1) Allow individuals the free choice of any qualified Medicaid provider within the specified geographic area identified in the plan when obtaining case management services, in accordance with § 431.51 of this chapter, except as specified in paragraph (b) of this section.

(2) Not use case management (including targeted case management) services to restrict an individual's access to other services under the plan.

(3) Not compel an individual to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services.

(4) Indicate in the plan that case management services provided in accordance with section 1915(g) of the Act will not duplicate payments made to public agencies or private entities under the State plan and other program authorities;

(5) Provide comprehensive case management services, on a one-to-one basis, to an individual through one case manager.

(6) Prohibit providers of case management services from exercising the agency's authority to authorize or deny the provision of other services under the plan.

(7) Require providers to maintain case records that document for all individuals receiving case management as follows:

(i) The name of the individual.

(ii) The dates of the case management services.

(iii) The name of the provider agency (if relevant) and the person providing the case management service.

(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.

(v) Whether the individual has declined services in the care plan.

(vi) The need for, and occurrences of, coordination with other case managers.

(vii) A timeline for obtaining needed services.

(viii) A timeline for reevaluation of the plan.

(8) Include a separate plan amendment for each group receiving case management services that includes the following:

(i) Defines the group (and any subgroups within the group) eligible to receive the case management services.

(ii) Identifies the geographic area to be served.

(iii) Describes the case management services furnished, including the types of monitoring.

(iv) Specifies the frequency of assessments and monitoring and provides a justification for those frequencies.

(v) Specifies provider qualifications that are reasonably related to the population being served and the case management services furnished.

(vi) Specifies the methodology under which case management providers will be paid and rates are calculated that employs a unit of service that does not exceed 15 minutes.

(vii) Specifies if case management services are being provided to Medicaid-eligible individuals who are in institutions (except individuals between ages 22 and 64 who are served in IMDs or individuals who are inmates of public institutions).

(viii) Specifies if case management services are being provided to individuals with long-term stays of 180 consecutive days or longer or to individuals with short-term stays of less than 180 consecutive days. When States choose to provide case management services to individuals in institutions to facilitate transition to the community, the State plan must include the following requirements:

(A) Specify the time period or other conditions under which case management may be provided in this manner. The time period that case management is provided in an institution must not exceed an individual's length of stay;

(B) Specify the case management activities and include an assurance that these activities are coordinated with and do not duplicate institutional discharge planning;

(C) Include an assurance that the amount, duration, and scope of the case management activities would be documented in an individual's plan of care which includes case management activities prior to and post-discharge, to facilitate a successful transition to community living; and

(D) Specify that case management is only provided by and reimbursed to community case management providers;

(E) Specify that Federal Financial Participation is only available to community providers and will not be

claimed on behalf of an individual until discharge from the medical institution and enrollment in community services; and

(F) Describe the system and process the State will use to monitor providers' compliance with these provisions.

(9) Include a separate plan amendment for each subgroup within a group if any of the following differs among the subgroups:

(i) The case management services to be furnished;

(ii) The qualifications of case management providers; or

(iii) The methodology under which case management providers will be paid.

(b) If the State limits qualified providers of case management services for target groups of individuals with developmental disability or chronic mental illness, in accordance with § 431.51(a)(4) of this chapter, the plan must identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.

(c) Case management does not include, and FFP is not available in expenditures for, services defined in § 440.169 of this chapter when any of the following conditions exist:

(1) Case management activities are an integral component of another covered Medicaid service.

(2) The case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including, but not limited to, services under parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services, and foster care programs.

(3) The activities are integral to the administration of foster care programs, including but not limited to the following:

(i) Research gathering and completion of documentation required by the foster care program.

(ii) Assessing adoption placements.

(iii) Recruiting or interviewing potential foster care parents.

(iv) Serving legal papers.

(v) Home investigations.

(vi) Providing transportation.

(vii) Administering foster care subsidies.

(viii) Making placement arrangements.

(4) The activities, for which an individual may be eligible, are integral to the administration of another non-medical program, such as a

guardianship, child welfare/child protective services, parole, probation, or special education program except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Act.

(5) Activities that meet the definition of case management services in § 440.169 and under the approved State plan cannot be claimed as administrative activities under § 433.15(b).

(d) After the State assesses whether the activities are within the scope of the case management benefit (applying the limitations described above), in determining the allowable costs for case management (or targeted case management) services that are also furnished by another federally-funded program, the State must use cost allocation methodologies, consistent with OMB Circular A-87, CMS policies, or any subsequent guidance and reflected in an approved cost allocation plan.

(Catalog of Federal Domestic Assistance Program, No. 93.778, Medical Assistance Program.)

Dated: June 23, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: August 27, 2007.

Michael O. Leavitt,

Secretary.

[FR Doc. 07-5903 Filed 11-30-07; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 300

RIN 0648-XD77

Notification of U.S. Fish Quotas and an Effort Allocation in the Northwest Atlantic Fisheries Organization (NAFO) Regulatory Area

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: NMFS announces that fish quotas and an effort allocation are available for harvest by U.S. fishermen in the Northwest Atlantic Fisheries Organization (NAFO) Regulatory Area. This action is necessary to make