MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING AND ADULT SERVICES AGENCY

CARE MANAGEMENT (CM) PERFORMANCE CRITERIA

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CARE MANAGEMENT PERFORMANCE CRITERIA

The Michigan Department Health and Human Services (MDHHS) - Aging and Adult Services Agency (AASA) provides an annual allocation of funds to Area Agencies on Aging (AAAs) for the purpose of administering the Care Management Program. Programs shall be operated in compliance with the Operating Standards for Service Programs, General Requirements for Access Service Programs, Standard A-1: Care Management, and with policies and procedures delineated in this document.

SERVICE DESCRIPTION

Definition

Care Management (CM) is the provision of a comprehensive assessment, plan of care development, periodic reassessment, and ongoing coordination and management of in-home and other supportive services to individuals who are aged 60 and over who are medically complex and at risk of or in need of a nursing facility level of care due to functional and/or cognitive limitations.

Using a person-centered planning process, services are brokered or directly purchased, according to an agreed-upon service plan, to assist the participant in maintaining independence. CM activities include assessment, service plan development, service arranging/follow up and monitoring and reassessment. Activities are designed to enhance participant autonomy, respect participant preferences, support caregivers and promote efficient use of available resources.

Primary Goals

The goals of CM are:

1. To delay and/or prevent costly, premature or inappropriate institutionalization of high risk older adults.
2. To define appropriate levels of care to assist older adults in maintaining independence by utilizing available informal (unpaid) and formal (paid) supports.
3. To provide minimal levels of support necessary to enable caregivers to continue their support for the participant.

Eligibility for CM Services

The Care Management Program serves individuals who are:

- aged 60 and over
- medically complex with functional and/or cognitive limitations
- at risk of, but not necessarily in need of, a nursing facility level of care
- in need of a nursing facility level of care, but not eligible for Medicaid-supported long term care services

A person at risk demonstrates one or more of the following characteristics:

- Determined medically eligible for nursing facility placement; or
- Functionally unable to provide self-care without assistance due to illness or declining health and without sufficient support for meeting care needs; or
- Multiple, complex and diverse service needs; or
- A weak or brittle informal support system or
- Currently resides in a nursing home, but because of insufficient resources and lack of other supports, is unable to obtain needed community services to return home.

Eligibility for CM is determined through a formal assessment. Eligibility to participate is not based on a person's level of income. AAAs may develop written criteria to further target low income individuals, however participation may not be denied because individuals do not meet low income criteria.

Primary CM Functions

Care management includes all of the following functions:

1. Assessment
2. Person-Centered Service Plan Development
3. Service Arranging
4. Follow-up / Monitoring
5. Reassessment

Assessment - Comprehensive in-person examination of an individual's health status, physical and social/emotional functioning, medications, physical environment, informal support potential and financial status.

Person-Centered Service Plan Development - A written plan of service which states specific interventions to be secured. The participant and the care manager establish which services will be secured and provided, as well as the frequency and duration of services. Each service is approved by the participant or his/her representative and by physicians when required by funding sources. The total service plan is approved by the participant prior to implementation of services.

Service Arranging - In-home health and social services are arranged and/or purchased by care managers according to the frequency and duration established by the participant and care managers as approved by the participant in the service plan. Care managers serve as agents of the participant in negotiating, arranging and monitoring formal services. Care managers arrange services from participant-approved service plans by establishing the frequency and duration of services within the regulatory and capacity limitations of providers. Care managers serve as consultants to physicians when arranging direct services that require physician approval. Person-centered advocacy is conducted to ensure access to, and appropriate utilization of, community services.

Follow-up / Monitoring - Ongoing periodic contact with participants and service providers is conducted to ensure service plans are implemented as planned and service needs are being met.

Reassessment – Comprehensive in-person reexamination of the participant's physical and social/emotional functioning, medications, physical environment, informal support potential and financial status.

Additional CM Functions

Gap Filling - Efforts such as purchasing services and equipment are provided to fill crucial identified needs that are not met by existing informal and formal resources.

Social-emotional support - Provided by care managers to participants and their families to facilitate life adjustments and bolster informal support. Family case conferencing is conducted as necessary.

Identification of unmet needs – Care managers document services not currently available to meet the needs of participants. Compilation and analysis of unmet needs information can be useful for AAA planning purposes.

Advocacy - Provided by care managers to assist participants and their families to gain benefits and services they may be entitled to. Care managers assist in accessing public (Medicare/Medicaid) and other third-party benefits and services.

Administration and Coordination of CM

AAAs are authorized to administer care management as a direct service under the Older Americans Act. If subcontracting the service, AAAs ensure that CM providers are service neutral, that is agencies that authorize services for CM participants may not provide those services directly, or have direct or indirect ownership or controlling interest in, or a direct or indirect affiliation or relationship with an entity that provides services other than care management, except where there is no other viable provider and a waiver is granted by AASA.

CM agencies must establish arrangements with direct service providers to define operating parameters and avoid duplication in assessment, reassessment and service arrangement functions.

AAAs are responsible for implementing these standards whether CM is provided directly by the AAA or subcontracted.

Standards of CM Performance

1. Program activities shall be conducted in accordance with the values and elements of person-centered planning. Individuals receiving care management services shall have the opportunity to identify and express their goals, choices and needs, and receive services and supports that contribute to realizing goals, honoring choices, and meeting needs. The role of the care manager is to support and facilitate the individual in maintaining the highest level of functioning and independence possible.

2. The participant shall sign a consent to participate which assures their right to accept or refuse services. The consent form shall be signed at assessment and contain the following information:

a. participant's agreement to participate in the program
b. acknowledgement that participant is fully informed of the information in the consent document
c. acknowledgement of the participant's right to receive or refuse services
d. a statement that the consent to participate may be revoked upon request of the participant or his/her proxy when the participant is determined legally incompetent or physically unable to withdraw consent to participate

3. The participant's right to privacy shall be assured. The law (Privacy Act of 1974, as amended, 5USC, Subsection 552a and 42 CFR 431.300-.307) treats all communication with the participant as confidential, whether oral or written, including records derived from such communications. Information disclosed by the participant to the care manager shall be held in strictest confidence and may be released only with prior written consent.

4. The participant shall authorize the use or disclosure of health information protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The written authorization shall include the following information:
   a. permission to use or disclose protected health information (PHI) for purposes beyond treatment, payment or health care operations
   b. a description of the PHI to be disclosed
   c. purpose for the disclosure
   d. the intended recipient
   e. the date the authorization expires

5. Qualified staff conduct CM functions. CM functions shall be conducted by a multi-disciplinary team. A team may consist of a registered nurse and a licensed social worker (as described within the Michigan Public Health Code) or be comprised of a registered nurse and an individual with a minimum of two years CM experience. .

6. Each program shall require and thoroughly check references of paid staff that will be entering participants' homes. In addition, each program must conduct a criminal background check through the Michigan State Police for each paid and/or volunteer staff person who will be entering participants' homes.

7. Care managers are provided direct supervision in the conduct of program activities.

8. Care managers shall receive in-service training at least twice each fiscal year that is specifically designed to increase their knowledge and understanding of the program and participants, and to improve their skills in completion of job tasks.

9. Care managers shall strive to establish and maintain a positive working relationship with participants.

PROGRAM EDUCATION AND REFERRAL

In an effort to facilitate appropriate referrals to the program, staff provide education to potential referral sources to raise awareness, describe characteristics of the target population, and explain screening criteria. Potential referral sources include key agencies serving the target population (hospitals, home care agencies, human service agencies, and other community agencies) and family/friends.

The AAA shall establish written procedures for managing referrals during periods of time when there is demand for care management services that exceeds program capacity.

SCREENING

Following referral to CM, all applicants are screened to determine their level of need and willingness to receive CM services. Eligibility for an assessment is determined through a screening process utilizing the MI Choice Intake Guidelines (MIG). The MIG, instructions and scoring algorithm can be accessed in the Center for Information Management's (CIM's) COMPASS assessment system.

The screen represents a formal request for participation in the program. The screening process evaluates the applicants' health, social, emotional and environmental needs, and their abilities and needs in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). It considers the level of caregiving currently provided to the applicant, whether that care will continue, and the amount of additional assistance needed.

Referrals are screened through direct questioning of the individual seeking CM services whenever possible. Direct questioning may occur either by telephone or in person. Screening may involve a proxy and/or a referral source to confirm the applicant's need and willingness to receive CM and in-home services.

Screen questions are to be asked as worded, however may be administered flexibly, rather than in the order they appear on the standardized tool. Additional probative questions are permissible when needed to clarify eligibility. All sections of the screen must be completed and scored.

Applicants who score into Section A are not usually eligible for a CM assessment, and if found not eligible, shall be provided information and referral to a program, agency or community services appropriate to meet their needs. Applicants who score in sections B and C may be eligible for and offered an assessment. Applicants who score in sections D, D1 or E are likely eligible for and should be offered a formal assessment.

Any time the program is at capacity, a list of individuals screened and awaiting assessment shall be established and maintained. At a minimum, the waiting list shall include the name, address, telephone number, referral source, date of screen, and total score. Where program resources are insufficient to meet the demand for services, each CM program shall establish and utilize written procedures for prioritizing clients waiting to receive services, based on social, functional and economic needs.

Minimum Requirements: Screening

1. The AAA shall establish written procedures for all staff performing screening functions.

2. The screen shall be completed and scored using the criteria listed above.

3. Applicants determined not eligible for an assessment shall be provided information and referral to a program, agency or community services appropriate to meet their needs.

4. Referral source and proxies shall be notified of the outcome of the screen.

5. Screen information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

ASSESSMENT

The interRAI Home Care Assessment System (IHC) is the basis for the CM Assessment. It is designed to be comparable to the resident assessment instrument congressionally mandated for use in nursing facilities. Care Managers use the IHC to perform a comprehensive evaluation

including assessment of the individual's unique preferences: physical, social and emotional functioning; physical environment; natural supports; and financial status.

The assessment requires direct questioning of the applicant and the primary caregiver, if available, observation of the applicant in the home environment, and a review of secondary documents. Whenever possible, the applicant is the primary source of information and the assessment should be performed in the applicant's place of residence.

The IHC and Clinical Assessment Protocols (CAPs) can be accessed in CIM's COMPASS assessment system under the Help tab**.**

Role of the Family and Caregivers in Assessment Process

The applicant is the primary focus of the assessment and information is gathered from the applicant whenever possible. In addition, family members and caregivers are an essential part of the applicant's support system. With the applicant's permission, their input is elicited as part of the assessment whenever possible.

At the expressed desire of the applicant, or in instances where the applicant is unable to fully participate in assessment activities, input may be sought and accepted from a proxy source, such as a spouse, adult child, a primary caregiver, or another individual involved in the applicant's care on an on-going basis.

In instances where a guardian is assigned to make decisions on behalf of an individual, the guardian must be included in the assessment process to make decisions over which he/she has authority.

Role of Other Professionals, Physicians in Assessment Process

Due to the medical complexity of individuals enrolled in the program, care managers may receive medical information from a physician or other professionals involved with the participant with the participant's written permission. Coordination of care with medical providers allows for a comprehensive service plan.

Minimum Requirements: Assessment

1. Each individual scheduled for assessment shall have been screened for participation in the program.

2. The assessment shall be conducted with active participation of the applicant within 30 calendar days of completion of the screen.

3. The assessment shall be conducted by qualified staff as previously described above.

4. The assessment shall be conducted face-to-face in the applicant's place of residence. For individuals assessed in a setting other than their home, such as a hospital or nursing care facility, care managers shall conduct a home visit within 14 days to assess the proposed living environment.

5. The assessment shall be conducted in its entirety according to the IHC Assessment Form and CAPs.

6. The following activities are conducted as part of the assessment interview:
   a. Discuss with the applicant feasible alternatives to receiving long term care
   b. Secure in writing the applicant's informed consent
   c. Secure in writing the applicant's consent to release confidential information
   d. Secure in writing the applicant's consent to disclose protected health information for purposes beyond treatment, payment, or health care operations as applicable
   e. Inform the applicant of the right to appeal actions and decisions

7. Assessment information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

IHC CLINICAL ASSESSMENT PROTOCOLS AND TRIGGERS

The IHC consists of the IHC Assessment and the CAPs. The IHC Assessment Form is the component that enables a care manager to assess multiple key domains of function, health, social support and service use. Particular items also identify individuals who could benefit from further evaluation of specific problems or risks for functional decline. These items, known as triggers, link the assessment to a series of problem-oriented CAPs.

Overview, Purpose/Use

The CAPs contain general guidelines for further assessment and individualized care planning for participants who present issues in trigger conditions. There are multiple CAPs that respond to participant needs in multiple domains. The focus is not just on simple maintenance services or planning a response to an immediate problem. While these are included, the use of CAPs helps clinicians assess for opportunities to rehabilitate function, prevent decline, and maintain participants' strength. In responding to urgent needs, care priorities can be identified. In looking at chronic problems, comprehensive well-being can be maintained.

Role in Service Plan Development

An accurate assessment lays the groundwork for all that follows – problem identification, identification of causes and associated conditions, and specification of necessary service goals and related service approaches. The average participant will trigger on 10-14 CAPs. Problems will be identified in many areas, prompting further review through an in-depth evaluation of problems. The in-depth evaluation of problems helps care managers to think through why a problem exists or why the participant is at risk, providing the necessary foundation on which to base next steps.

PERSON-CENTERED SERVICE PLAN DEVELOPMENT

Person-centered planning is the guiding principle behind service plan development. The Person-Centered Service Plan is a written document detailing the full spectrum of supports and services provided to the participant. It is designed to respond to problems and concerns identified through the assessment, as well as a participant's expressed choices and needs. The service plan shall maximize the participant's strengths, personal control and independent living, while addressing the problems and/or concerns that affect health, safety and quality of life. It takes into consideration the whole person, rather than only those services and supports provided through the care management program. That includes a participant's natural support system and what is needed to support those involved in a caregiving role. The service plan prioritizes those services necessary to address basic health and safety issues.

Participants have the right to choose who will provide the services indicated in the service plan from among providers under contract with the AAA or enrolled in the direct purchase provider pool. If the participant has no preference of provider, the care manager shall select a provider on

their behalf based on established selection criteria (quality, availability and cost) for final approval by the participant.

Required Service Plan Elements

There is no required service plan format. Programs may utilize an existing form or develop their own as long as required elements are included. Required elements include:

- Participant identification number
- Identification of each issue, need, problem, and what it is related to.
- Planned intervention for each issue/need/problem
- Planned goal and outcome for each issue/need/problem
- Date intervention is initiated (start date)
- Date goal is met (stop date)
- Frequency and duration of service
- Participant approval (verbal or in writing) or other disposition (participant will or will not consider)
- Signatures of assigned care managers

Developing Goals and Interventions

The service plan shall clearly identify each issue, need, or problem identified during the assessment, reassessment or regular contact with the participant regardless of whether the resulting intervention is on a formal (paid) or informal (arranged) basis.

Goals shall be established for each recommended intervention. The service plan shall clearly identify the intended goal of each intervention. Goals shall be outcome based and measurable through ongoing review during subsequent contact with the participant.

A recommended intervention shall be developed to alleviate identified problem, need or condition. The service plan shall identify recommended frequency of intervention.

Resource Utilization/Allocation Strategies

Exploration of the potential resources for supports and services to be included in the participant's service plan shall be considered in this order:

- The participant

- Family, friends, guardian and significant others
- Resources in the neighborhood and community
- Publicly-funded supports and services

Planning shall address participant's needs with the focus on providing the minimum level of formal services necessary to support the informal caregiver(s) to continue involvement in the provision of care. Services shall not be used to supplant existing informal care except in situations where the provision of services is expected to extend the ability of caregivers to provide continuing support to the participant.

To the greatest extent possible, services from informal caregivers (family, neighbors, and friends) and/or community agencies who provide services at no charge are maximized prior to purchasing services.

Participants may provide financial support toward the cost of the services in accordance with locally established cost sharing practices. Under no circumstances shall services be denied for failure to contribute toward the cost of care.

The program shall pursue and secure all available third-party funding. Effort shall be made to maximize the coordination of skilled and home health benefits funded through Medicare. The programs shall also maximize use of regular Medicaid state plan benefits, veteran's benefits, insurance benefits, and other sources of long term care available to the participant, including patient pay in instances where unused monthly income may result in excess assets if allowed to accumulate over time.

Minimum Requirements: Person-Centered Service Plan

1. A written person-centered service plan shall be developed for each participant within 14 days of assessment.

2. The service plan shall be developed with active involvement of the participant.

3. Others, including family members and caregivers, may be involved allies as deemed appropriate by participant. If the participant has a guardian, the guardian must be involved in service planning activities.

4. The service plan considers the participant's IHC assessment, CAPs and triggers in development of necessary service goals and related service approaches. It shall include all required elements described under Required Service Plan Elements above.

5. The participant shall approve the service plan prior to implementation of services. Signature on the service plan designates approval. If the care manager is unable to obtain signature, verbal approval may be obtained for purposes of initiating services. The case record shall document the name of staff person obtaining and date of verbal approval. The participant's signature must be obtained during the next home visit.

5. Service plan information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

SERVICE ARRANGING

Care managers arrange services from participant-approved service plans by establishing the frequency and duration of services within the regulatory and capacity limitations of providers. Person-centered advocacy is conducted to ensure access to, and appropriate utilization of, community services.

Minimum Requirements: Service Arranging

1. Participant preference in selection of service providers from among those under contract or enrolled in a direct purchase provider pool with the AAA shall be ensured.

2. Care managers shall serve as agents of the participant in negotiating and arranging formal and informal services.

3. Care managers shall serve as the liaison to the participant's personal physicians and secure approval for service when service plans specify arranging services that require physician approval.

4. A written service authorization shall be completed and submitted to service providers. The service authorization shall delineate each formal service arranged or purchased under the participant's service plan and specify the frequency and duration of service delivery.

FOLLOW-UP / MONITORING

Follow-up and monitoring include contact between the care managers, the participant and/or service providers to ensure providers deliver services as planned and to the satisfaction of the participant. Follow-up and monitoring are the processes used to evaluate the timeliness, appropriateness and quality of services implemented under the participant service plan. All services implemented on behalf of participants are monitored by care managers as a function of service planning and reassessment.

Minimum Requirements: Follow-Up / Monitoring

1. Follow-up and monitoring is provided to all CM participants. Care managers shall be in contact with participants on at least a monthly basis unless otherwise specified by the participant.

2. Care managers shall serve as agents of the participant in monitoring formal and informal services.

3. Care managers contact newly enrolled participants within fourteen (14) days of the agreed upon service start date to verify that services are provided in the manner arranged and to the satisfaction of the participant. Case Managers may contact the service provider in addition to the participant to verify service provision and identify any issues identified by the provider.

4. Each follow-up/monitoring contact and date is documented in the participant case record.

5. Changes in services negotiated during follow-up/monitoring contacts on behalf of participants are recorded in the case record.

6. Care managers provide oral and/or written feedback to providers regarding services provided according to the service plan when care managers receive participant concerns or complaints.

7. When care managers attempt to arrange a service that cannot start within 30 days due to a waiting list for the service, care managers must contact the provider agency every 30 days until the service is implemented.

REASSESSMENT AND/OR PERSON-CENTERED SERVICE PLAN REDEVELOPMENT

Reassessment provides a scheduled, periodic in-person reexamination of participant functioning for the purpose of identifying changes that may have occurred since the previous assessment and to measure progress toward meeting specific goals outlined in the participant service plan. It provides a basis upon which care managers make recommendations for service plan adjustments. The IHC is used for reassessments and completed according to the assessment guidelines found above.

Person-Centered Service Plan redevelopment is a process whereby the care manager, participant and allies meet between the previous and next scheduled assessment to review, refine and improve the last person-centered service plan. The focus is specifically on providing more time for the care manager to support and coordinate a better plan as defined by the participant and their chosen support system.

Minimum Requirements: Reassessment and/or Person-Centered Service Plan Redevelopment

1. An in-person re-assessment is conducted 90 days after the initial assessment.
2. An in-person reassessment (or an in-person, person centered planning meeting with a redeveloped service plan) is completed 180 days after the first/previous re-assessment.
3. An in-person re-assessment is conducted 180 days after the previous reassessment or person centered planning meeting with a redeveloped service plan.
4. Repeat the 180-day cycle as listed in number 2 and 3 above.
5. A reassessment is conducted sooner when there are significant changes in the individual's health or functional status, or significant changes in the individual's network of allies (i.e. death of a primary caregiver).
6. Reassessment information is collected on a standardized form and included in the participant case record.
7. Either a multi-disciplinary CM team or an individual care manager can perform reassessments. A team is not required to perform reassessments.

8. Reassessment findings are reviewed with the participant and others as deemed appropriate by the participant. The service plan may be updated, based on mutually agreed upon changes.

9. Reassessment/redeveloped service plan information shall be submitted to the state's data warehouse through the designated data exchange gateway on at least a monthly basis.

CASE CLASSIFICATION

Case status shall be designated for each participant. The following case classifications shall apply to the Care Management Program:

AASA/CM = State or Federal Funded Care Management through AASA
The participant is enrolled in the AASA Care Management Program.

TCM = Targeted Case Management
The participant is enrolled in the AASA Care Management Program; and
Financially eligible for community Medicaid; and
Meets NFLOC criteria; and
Enrolled in the TCM Program.

Participants are closed to the CM Program when one of the following occurs:

1. The participant moves from the service area.
2. The participant is institutionalized on a permanent basis.
3. The participant terminates involvement with the program (e.g., refuses service).
4. The participant stabilizes to a point that care management intervention is no longer required.
5. Death.

Minimum Requirements: Case Classification

1. Each participant shall be assigned a case classification.

2. A reason for transferring participants from one classification to another shall be clearly documented in the participant case record.

3. The participant and/or proxy shall be informed of case closure in writing except when the

reason for case closure is death.

4. The participant and/or proxy shall be informed of procedures to be followed to re-enter the program if the need for intervention changes.

5. Case classification information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

COST SHARING

If the CM Program bills for and receives reimbursement through the Medicaid TCM program it must have a cost sharing process in place for the state funded AASA/CM service for non-Medicaid eligible individuals (Reference AASA TL #393). Cost sharing for in-home services arranged or purchased on behalf of care management participants are treated separately and not included under this requirement

It is the responsibility of the care manager or other designated staff to explain cost sharing to the participant and determine the cost share amount. This activity is most often accomplished during the assessment visit. On a locally determined schedule, a statement shall be sent to the participant requesting payment of the predetermined cost share amount. Subsequent cost sharing shall be conducted on at least a quarterly basis. Funds generated as a result of CM cost sharing shall be used to support the program.

Minimum Requirements: Cost Sharing

1. Programs that participate in the Medicaid TCM Program shall have a cost sharing process in place for non-Medicaid eligible individuals.

2. Programs shall establish sliding fee schedules based on reasonable gradations of income consistent with the standard of living in the service area to be applied to all individuals enrolled in the program. Cost share amount for participants whose incomes are at or below 100% of the federal poverty level shall be zero.

3. Programs shall establish written policies and procedures to guide administration of cost sharing.

4. Individuals may not be denied participation in the program for failure to contribute cost share. Participant records shall reflect that an attempt was made to collect the cost share.

CONFLICT RESOLUTION

Conflicts between participants and care managers shall be resolved through direct negotiation. If negotiation fails, participant/care manager conflicts shall be referred to the care management supervisor for discussion and resolution. All conflicts not immediately resolved through negotiation shall be documented in the case record.

Programs shall have written participant grievance procedures. Participants shall be provided a copy of the participant grievance procedure at the time of assessment at a minimum. A copy shall also be provided upon participant request. In situations where professional judgment indicates that a change in services is appropriate and the participant does not agree to the change, the participant shall be provided with written information on how to appeal decisions.

When conflicts between participants and service providers arise, care managers shall negotiate resolution to ensure implementation of the service plan to the participant's satisfaction. Resolution may include obtaining services from an alternate provider.

Conflict of professional judgment may arise during the development, implementation and monitoring of the participant service plan. Conflicts between care managers and service providers shall be resolved to promote the implementation of the service plan to the participant's satisfaction. If a conflict between care managers and service providers cannot be readily resolved through direct negotiation, the issue shall be referred to the care management supervisor and service provider supervisor for resolution.

CASE RECORDS MAINTENANCE

Records shall be maintained in a detailed and comprehensive manner that conforms to good professional practice, permits effective professional review and audit, and facilitates an adequate system for follow-up.

Programs shall have written policies and procedures in place for maintenance of records to insure that records are documented accurately and promptly, are readily accessible, and permit prompt and systematic retrieval of information.

Minimum Requirements: Case Records Maintenance

1. A case record shall be established and maintained for each participant served.

2. At a minimum, the case record shall include, but is not limited to the following:
   - Completed eligibility screen
   - Completed assessment and reassessments
   - Consents to release confidential information
   - Participant-approved person-centered service plan
   - Service orders and instructions to providers
   - Progress notes for documenting participant progress/status, contacts with participant, providers and others involved in caring for the participant
   - Other documentation and correspondence sufficient to fully disclose the quantity, quality, appropriateness and timeliness of services provided

3. Case record entries shall be signed or initialed by each care manager making the case record entry. When initials are used, a signature log shall be maintained with employee name, initials and position/title. Case records may be on paper or electronically via date, time, case manager identification or certification (such as in COMPASS).

4. CM programs shall establish local procedures to ensure documentation is completed in a timely manner.

5. Records shall be retained for a minimum of six years following case closure.

QUALITY ASSURANCE / QUALITY IMPROVEMENT

Quality assurance activities are undertaken to determine participant satisfaction with both care management and the services that result from service plan implementation, and to ensure program compliance with established performance criteria. Quality improvement is undertaken to address identified program deficiencies.

Participant Satisfaction

Programs shall establish specific participant-oriented methods to measure and assure quality, and the frequency with which the methods will be applied. Participant satisfaction should be

determined through direct questioning as part of routine activity as well as through written surveys which seek general and/or specific feedback. At a minimum, surveys should address all aspects of care management service delivery, including the degree to which the principles and elements of person-centered planning are utilized in identifying and addressing a participant's needs and desires. Information obtained through participant surveys shall be used to guide both internal and external quality improvement initiatives.

State-Level Performance Review

The CM Program will be evaluated by the assigned AASA field representative as part of the Annual AAA Assessment process. The AAA completes the AASA Care Management Program Assessment Section of the Area Agency on Aging Assessment Guide prior to the assessment visit. The assigned field representative reviews the AAA responses in the Care Management Assessment Section, addresses issues that may come up and reviews documentation of CM protocols and practices as needed during the AAA Assessment visit.

The assigned field representative also reviews a minimum of five CM participant case records to assess whether required documentation is present.

If the CM Program is a TCM provider, the field representative will review at least 2 TCM cases and verify that applicable assessment/reassessment, care planning service arranging, follow-up/monitoring, progress notes and authorized signatures, identifications or certifications are in place to support TCM billing.

Program Level Performance Review

Programs shall establish internal processes to ensure program quality and compliance with established criteria. Such processes shall also be considered clinical peer review to ensure timeliness, completeness and appropriateness of care management activity undertaken on behalf of a participant. Program level performance reviews may be carried out internally if the program has multiple care management teams. Programs with a single team must conduct peer reviews externally in collaboration with another AASA-funded care management program.

Program level performance reviews shall be conducted a minimum of annually. The care manager responsible for the case may not conduct a review of his/her own cases. The number of cases reviewed shall be equal to 10% of the active case load. Programs are responsible for

establishing methodology for selection of cases. AAAs who subcontract all or part of the care management program are required to review programmatic, financial and contractual data of subcontracted providers on an annual basis. Utilizing a locally determined procedure, the AAA shall review subcontractor performance against established standards, policies, and procedures. The review shall include a review of state and agency policies and procedures related specifically to care management, as well as review for compliance with contractual requirements. The AAA will provide a written report of findings and recommendations to the subcontracted provider.

TARGETED CASE MANAGEMENT

The purpose of Targeted Case Management (TCM) is to provide AAAs with resources for managing the community-based care needs of Medicaid eligible persons age 60 and older who are not enrolled in the MI Choice waiver program. Provided under auspices of the AASA CM program, TCM is both a program type and a funding source. It is a Medicaid State Plan service (Revision HCFA-PM-87-4, March 1987) approved for a specific participant population (see Target Group C / Eligibility below). TCM Providers must meet federally-approved criteria to qualify for TCM participation. AASA is responsible for certifying that providers meet criteria on an annual basis. The certification is conducted as part of the AASA Annual AAA Assessment process.

Medicaid is a federal/state jointly funded program. TCM providers are reimbursed only for the annually-adjusted federal percentage portion (FMAP) of approved in-person encounters when billable activities occur. The annual AASA CM allocation is considered the state share contribution.

Target Group C / Eligibility

The target group consists of persons who are:

- At least 60 years old and disabled, or at least 65 years old; and
- determined to meet NFLOC criteria; and
- Seeking admission to, or at risk of entering a nursing care facility; and
- Eligible and enrolled in the AASA Care Management Program; and
- Documented as having multiple, complex and diverse service needs and a lack of capacity and support systems to address those needs without case management.

CM participants who fall into this target group and also meet community Medicaid financial eligibility shall be assigned a case classification of TCM.

Qualifications of TCM Provider Agencies

TCM provider agencies must be certified as meeting the following criteria:

- Demonstrated capacity to provide all core elements of case management services including:
  - client assessment and reassessment
  - service plan development
  - service arranging (linking/coordination of services)
  - monitoring and follow up of services

- Demonstrated experience in coordinating and linking community resources required by the target population.

- Demonstrated experience with the target population.

- Sufficient staff to meet the CM service needs of the target population.

- An administrative capacity to insure quality of services.

- Financial management capacity and system that provides documentation of services and costs.

- Capacity to document and maintain individual case records.

Qualifications of TCM Case Managers

TCM Case Managers shall be:

- a registered nurse (RN), licensed to practice in the state of Michigan;

- a social worker, Licensed to practice in the State of Michigan, or

- an individual with a minimum of two years case management experience

TCM billing will be disallowed for any period of time that a program operates without an RN on staff.

CM Activity Eligible for TCM Reimbursement

TCM reimbursement is available for in-person encounters during which one or more of the following billable activities occurs:
- Assessment;
- Service planning
- Service arranging
- Follow-up / Monitoring
- Reassessment.

Prescreening is not a billable activity. Do not bill in-person screening activities or any other CM activity not specifically identified above.

Case Manager Credentials for Billable Activity that is TCM Reimbursement Eligible

1. Only in-person billable activities are eligible for reimbursement.

2. When an RN or social worker conducts; an assessment, reassessment, service planning, service arranging or follow up/monitoring, it is considered TCM reimbursement eligible.

3. If an individual with a minimum of two years case management experience conducts a reassessment separate from an RN or social worker, either the RN or social worker must review and sign off on the reassessment to be considered TCM eligible.

4. If an individual with a minimum of two years case manager experience conducts service planning, service arranging, or follow up/monitoring it is considered TCM reimbursement eligible.

These TCM billing guidelines above replace Transmittal Letter #2018-169 TCM Billing and Reimbursement Guidelines.

Case Record Documentation

Case records must clearly document the purpose of the encounter and the individual conducting

the visit. Acceptable documentation includes either a Medicaid service log or completed assessment and/or reassessment documents and signed progress notes, whether on paper or electronically via date, time, case manager identification or certification (such as in COMPASS).

Claims Submission

Per Medicaid policy, encounters must be submitted for payment within 12 months of the date of service. AAAs are encouraged to submit claims on at least a quarterly basis. An exception to the 12-month rule is implemented for claims submitted at fiscal year end. Such claims must be submitted for processing within 45 days following the end of the fiscal year.

Medicaid identification numbers and eligibility dates should be verified prior to completing and submitting invoices. This information can be verified online by contacting MDHHS Eligibility Verification at:
http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-57088--,00.html

Providers without internet access:

- Contact Provider Inquiry at 1-800-292-2550 to verify eligibility.

Claims shall be prepared and submitted under the professional billing format described in the MDHHS Medicaid Provider Manual Billing and Reimbursement for Professionals available on the MDHHS website at:
http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Claims for services rendered must contain the name and individual national provider identifier (NPI) of the provider. As explained in the manual, all claims are submitted and processed through CHAMPS. MDHHS encourages claims to be submitted electronically. Once claims have been submitted and processed through CHAMPS, a remittance advice (RA) is produced to inform providers about the status of claims. Electronic CHAMPS RAs are sent for those choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent via paper if requested through the Provider Enrollment Subsystem. Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments. All claims, electronic or otherwise, must be formatted to HIPPA compliant MDHHS standards, and the files must be submitted to MDHHS for processing. MDHHS requires that NPI numbers be reported in any applicable provider loop or field on the claim

MDHHS processes claims and issues payments by check or EFT. An RA is issued with each payment to explain the payment made for the claim. If no payment is due or if claims have been rejected, an RA is also issued. If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. The electronic RA is produced in the HIPPA-compliant format. When a claim is initially processed, the claim adjustment reason/remark column on the RA identifies which service lines have been paid or rejected and edits which apply.

If a service line is rejected, a claim adjustment reason/remark code prints in the claim adjustment reason/remark column of the RA. The provider should review the definition of the codes to determine the reason for the rejection and verify that the provider NPI number and beneficiary identification number are correct.

Cash Receipt / Accounting

The Federal Medical Assistance Percentage (FMAP) rate is applied to the quarterly amount claim detail. The billing/reimbursement is for one monthly amount. The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year. The (FMAP is computed from a formula that takes into account the average per capita income for each state relative to the national average. The multiplier is based on the FMAP. For every dollar the state spends on Medicaid, the federal government matches at a rate that varies year to year. The correct calculation for the federal match rate for FY 2017 is based on $498.24 ($519 minus the 4% fee).

MDHHS centralized budget office distributes to AASA quarterly claim detail for each AAA in a Warrant Suspend report. AASA then applies the FMAP rate (Rate of FMAP changes from year to year), and sends a notification to each individual AAA of the availability and amount of each fund transfer (see Example A). To receive funds, the AAA must have an approved budget and submit a Cash Request to AASA through the online Aging Information System FIRST module.

Example A

Subject: AAA Targeted Case Management (TCM) Reimbursement - 1st Quarter FY 2017

Dear AAA Director,

Based on reporting and authorization from the DHHS Budget Office, your agency is now eligible to submit a cash request for the following amount related to Targeted Case Management (TCM). The Medicaid Reimbursement Rate for this period is .6515 for TCM.

$7,971.84 x 0.6515 = $5,194.00 (rounded)

You are eligible to submit a cash request for this amount.

Provider Name	Appropriation Number	Amount	Rate	Reimbursement
Region Area Agency on Aging	46511	$7,971.84	0.6515	$5,194.00

Please be advised: Federal OMB Circular A-133, Subpart B, Section .205(i) indicates that "Medicaid payments to a subrecipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis." Based on this section, the Michigan Department of Health and Human Services, Aging and Adult Services Agency, which is utilizing the cost-reimbursement basis, is requiring that TCM grant funds be treated as federal awards.

TCM Reimbursement Guidelines

MDHHS and AASA, which reimburse for TCM expenses on a cost-reimbursement basis, require that TCM funds be treated as federal awards.

Please be advised that the federal Office of Management and Budget's Circular A-133, Subpart B, Section .205(i) indicates that:

"Medicaid payments to a subrecipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis." (Reference Transmittal Letter #2013-264). The federal Health Care Financing Administration (HCFA)-TCM program, the Catalog of Federal Domestic Assistance (CFDA) number is 93.778.

Guidelines for Expenditure of TCM Reimbursement (Reference Transmittal Letter #2008-166):

I. Approved reimbursements from medical service billing claims made for case management activities under the approved Medicaid State plan amendment as allowed by P. L. 99-272 shall be returned to the AAA region and CM site that generated the revenue.

II. TCM reimbursement shall be used to directly support the care management program.

A. Earned reimbursements shall be expended for allowable costs in accordance with the approved budget. Allowable costs include: wages/salaries, fringe benefits, travel, supplies, occupancy, communications, administration, other, and purchase of services for program clients.

B. Non-allowable costs include equipment items defined as tangible items with a value of $5,000 or more, with a life expectancy greater than one year with the exception of computer hardware and/or software necessary to support the care management program and the MI Choice Information System (MICIS).

III. TCM revenues shall be reported and expended on an accrual basis.

A. TCM revenues shall be accounted for and expended during the fiscal year in which the original date of service occurred.

B. The care management grant provided by AASA serves as match for TCM reimbursement. That grant shall be reduced at fiscal year end by the amount of unspent TCM revenues.

C. Actual Medicaid claims approved during the first three fiscal year quarters shall be reported on the AASA Financial Status Report. The fourth quarter FSR shall reflect actual and estimated claims for the fiscal year.

D. The AAA shall submit a cash request for payment of TCM funds.