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Medicaid Targeted Case Management (TCM) Benefits

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Summary

Case management services assist Medicaid beneficiaries in obtaining needed medical and related services. Targeted Case Management (TCM) refers to case management for specific Medicaid beneficiary groups or for individuals who reside in state-designated geographic areas. Over the past six years of available data (1999-2005), total expenditures on Medicaid TCM increased from $1.4 billion to $2.9 billion, an increase of 107%. In comparison, over the same period, total Medicaid spending increased from approximately $147.4 billion to $275.6 billion, an increase of 86%.

TCM has been an active concern for both the executive and legislative branches. For instance, the Bush Administration proposed legislative changes to reduce Medicaid TCM expenditures in recent annual budget submissions. In the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), Congress added new statutory language to clarify the definition of case management and directed the Secretary of Health and Human Services to promulgate regulations governing how states may claim federal reimbursement under Medicaid for case management services, including TCM. As a result of this legislation, the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule on December 4, 2007, for case management, which took effect March 3, 2008. In the interim final rule, CMS estimated that the new case management rules would reduce federal Medicaid expenditures by approximately $1.3 billion between FY2008 and FY2012.

In early 2008, legislation was introduced (H.R. 5173, S. 2578, and H.R. 5613) that would impose a moratorium on changes to Medicaid case management services until April 1, 2009. In addition, the Indian Health Care Improvement Act Amendments of 2008 (S. 1200) was amended to delay implementation of the case management interim final rule until April 1, 2009. The House included a provision (H.Con.Res. 312, Sec.312) establishing a budget reserve that could be used to prevent or delay implementation of TCM and other Medicaid regulations, as long as this provision was in accordance with pay-as-you-go principles. Similarly, the Senate, in the FY2009 Concurrent Budget Resolution (S.Con.Res.70, Sec.306), created budget-neutral reserve funds that could be used to impose moratoria on implementation of Medicaid rules and administrative actions affecting Medicaid.

This report describes Medicaid case management services, presents major provisions of the proposed Medicaid case management regulation, and provides various perspectives on the TCM interim final rule. This report will be updated to reflect legislative and regulatory activity.

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Medicaid Case Management

Definition

Medicaid case management consists of services to assist eligible beneficiaries in obtaining medical and other services necessary for their treatment. Case management is not the *direct* provision of medical and related services, but rather is assistance to help beneficiaries receive care by identifying needed services, finding providers, and monitoring and evaluating the services delivered.[1] Targeted case management (TCM) refers to case management that is restricted to specific beneficiary groups. Targeted beneficiary groups can be defined by disease or medical condition, or by geographic regions, such as a county or a city within a state. Targeted populations, for example, may include individuals with HIV/AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities, children receiving foster care, or other groups identified by a state and approved by the Centers for Medicare and Medicaid (CMS). TCM and case management are optional services that states may elect to cover, but which must be approved by CMS through state plan amendment (SPAs).[2]

The Medicaid statute covering case management has been amended a number of times, most recently by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). Section 6052 of DRA added new language that further defined case management services (including TCM) and directed the Secretary of Health and Human Services to develop rules for states to follow in claiming reimbursement for case management expenditures under Medicaid. To this end, CMS issued an interim final rule[3] governing the use and claiming of Medicaid case management services.[4] As stipulated in DRA, the Secretary's case management interim final rule was open for

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[1] Under section 1905(a)(19) of the Social Security Act (SSA), states are given the option to cover case management and targeted case management in their Medicaid programs. Under Section 1915(g)(2), case management is defined as "services which will assist individuals eligible under the plan [Medicaid plan] in gaining access to needed medical, social, educational, and other services."

[2] For more information on optional and required benefits, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

[3] For a discussion of federal regulation, see CRS Report RL32240, *The Federal Rulemaking Proces: An Overview*, by Curtis W. Copeland.

[4] "Medicaid Program; Optional State Plan Case Management Services," Interim Final Rule, *Federal Register*, vol. 72, no. 232, December 4, 2007.

public comment for 60 days, until February 4, 2008. It became effective March 3, 2008.[5]

Expenditures

Almost all states cover TCM benefits.[6] Medicaid expenditures for TCM have increased rapidly. As shown in **Table 1**, total federal and state Medicaid TCM expenditures more than doubled between FY1999 ($1.4 billion) and FY2005 ($2.9 billion).[7] Nationally, during the same period, the number of beneficiaries receiving TCM increased 62.6%, from approximately 1.7 million in FY1999 to approximately 2.7 million in FY2005. Average TCM expenditures per beneficiary also increased from FY1999 to FY2005, rising by 26.9%. In comparison, overall Medicaid expenditures also increased rapidly over the same period, rising from approximately $147 billion in FY1999 to $276 billion in FY2005, an approximate 87% increase. The number of Medicaid beneficiaries also increased during this period, rising by 43.1%, from FY1999 (40.3 million) to FY2005 (57.7 million). During the same time period, average spending per Medicaid beneficiary increased by approximately 30.7%, from $3,657 in FY1999 to $4,781 in FY2005.

Table 1. Expenditures and Beneficiaries for Medicaid and TCM, FY1999 and FY2005

Expenditures/Beneficiaries	FY1999	FY2005	% Change
TCM (federal and state) Expenditures ($ billions)	$1.41	$2.90	105.7%
TCM Beneficiaries	1,687,440	2,744,027	62.6%
TCM Expenditures per beneficiary	$834	$1,058	26.9%
Total (federal and state) Medicaid Expenditures ($ billions)	$147.37	$275.57	86.9%
Medicaid Beneficiaries	40,300,394	57,652,988	43.1%
Medicaid (federal and state) Expenditures per Beneficiary	$3,657	$4,781	30.7%

Source: All Medicaid expenditure data discussed in this report include both federal and state expenditures, as well as expenditures for Medicaid-expansions under the State Children's Health Insurance Program (M-SCHIP). Congressional Research Service, based on Medicaid Statistical Information System (MSIS) data from CMS (downloaded December 14, 2007). FY2004 data were used for Maine as an estimate of FY2005 data.

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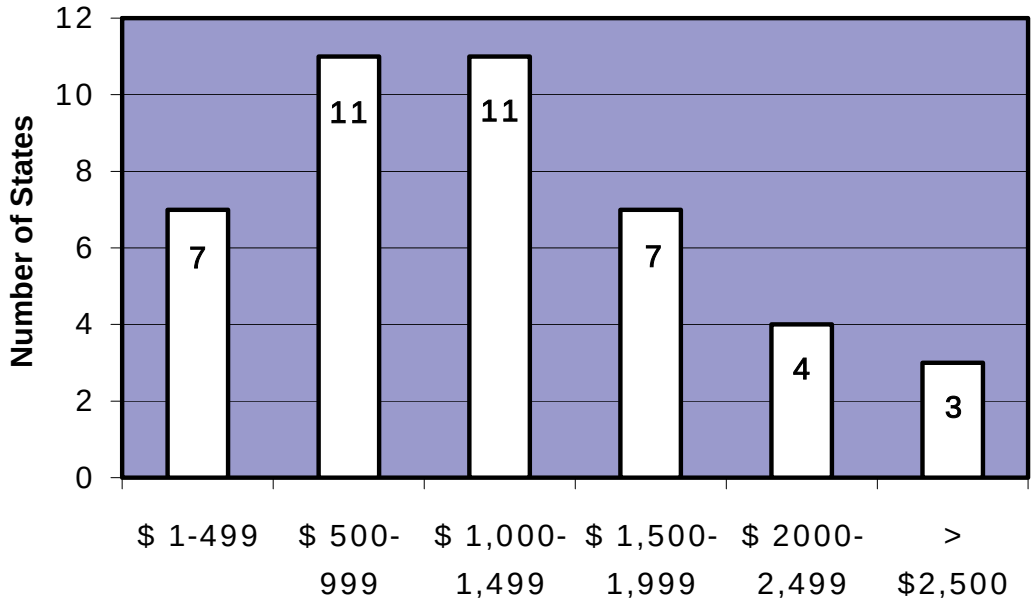
[5] Although the recently passed P.L. 110-173, Medicare, Medicaid and SCHIP Extension Act of 2007, contains a moratorium prohibiting changes to regulations affecting payments for Medicaid rehabilitation and school-based services until June 30, 2008, this moratorium does not apply to Medicaid case management.

[6] Delaware is the only state that does not cover TCM. See The Kaiser Commission on Medicaid and the Uninsured, Medicaid Benefits: Online Database (October 2006), at [http://www.kff.org/medicaid/benefits/service.jsp?gr=off&nt=on&so=0&tg=0&yr=3&cat=7&sv=40m], accessed March 4, 2008.

[7] Expenditures for the territories and amounts that are not directly attributable to beneficiaries' service use (e.g., administrative costs) are excluded. Maine MSIS data for FY2005 data were unavailable. As an estimate of Maine's FY2005 TCM expenditures and beneficiaries, FY2004 data were used.

Based on CMS reported data, total federal and state expenditures for TCM services in FY2005 ranged from approximately $535 million in California to approximately $872,000 in Hawaii (see **Table 2**). During the same period, the number of beneficiaries receiving TCM services ranged from 820,000 individuals in Illinois to 1,463 in Hawaii.[8] National per beneficiary TCM expenditures were $1,058 in FY2005, but per beneficiary expenditures for TCM expenditures varied considerably by state, ranging from $5,778 in Massachusetts to $116 per beneficiary in Ohio. In **Figure 1**, for comparison, states' per beneficiary expenditures for TCM are displayed in six expenditure level groupings. The majority of states that reported TCM expenditures in FY2005 spent between $500 to $1,500 per beneficiary on TCM. Although most states cover TCM, some do not show TCM expenditures in the Medicaid Statistical Information System (MSIS) database compiled by CMS from state-reported information. As shown in **Table 2**, six states and the District of Columbia reported no TCM expenditures in FY2005. Of these seven, Delaware is the only state that indicates it does not cover TCM.

Figure 1. States' FY2005 Medicaid TCM, Per Beneficiary Expenditures



Source: Congressional Research Service, based on Medicaid Statistical Information System (MSIS) data from CMS (downloaded February 28, 2008).

[8] Data are from the Medicaid Statistical Information System (MSIS) data. MSIS data are self-reported by states to CMS from their administrative information systems. States have discretion in determining which expenditure categories to use in reporting Medicaid spending.

Guidance to States

In the last days of the Clinton Administration (January 19, 2001), the CMS Director of Medicaid and State Operations issued a letter to state Medicaid and Child Welfare directors. Although the state Medicaid director letter (SMDL) addresses TCM claiming for children in foster care, it is often cited as guidance for states on how to claim TCM expenditures under Medicaid more generally.[9] The SMDL reiterated statutory language that broadly defined TCM and left states substantial flexibility on whether to cover and how to structure TCM services. In addition, the 2001 SMDL described examples that would be considered appropriate claiming of TCM expenditures.

Subsequently, in the early years of the Bush Administration, states received indirect guidance on TCM expenditure claiming from GAO and Health and Human Services Office of Inspector General (HHS/OIG) reports that were critical of state and CMS practices on TCM,[10] as well congressional testimony presented by CMS officials.[11] Moreover, in 2004, Maryland's state plan amendment to provide TCM services to children in the state's foster care program was denied, and an administrative appeal upheld that decision.[12] The denial of Maryland's SPA for foster care TCM[13] provided states additional unofficial information but, as found by GAO, contributed to ambiguity on TCM because other states were allowed to continue similar practices.[14] For example, GAO reviewed a sample of Massachusetts

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[9] State Medicaid director letter (01-013), accessed August 31, 2007, at [http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage].

[10] For example, see *Medicaid Financing, States Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight* (pp. 4-6), Report to the Chairman, Committee on Finance, U.S. Senate, U.S. Government Accountability Office, June 2005, at [http://www.gao.gov/new.items/d05748.pdf].

[11] Dennis Smith, Director, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, testimony to Senate Committee on Finance hearing on Medicaid Fraud and Abuse, June 28, 2005, at [http://finance.senate.gov/hearings/testimony/2005test/DStest062805.pdf].

[12] *Medicaid, States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight* (pp. 16-17), Kathryn G. Allen, Director, Health Care, Testimony Before the Committee on Finance, U.S. Senate, June 28, 2005, U.S. Government Accountability Office, at [http://finance.senate.gov/hearings/testimony/2005test/KATest062805.pdf]. In addition to Maryland, Illinois's (2002) TCM SPA was denied, and Texas's (2004) TCM claims were denied.

[13] There were three reasons for denying Maryland's SPA: (1) the services proposed by Maryland were not encompassed by the statutory definition of case management, (2) the SPA provided for payment for services available without charge, and (3) it restricted beneficiary freedom of choice by limiting providers to employees of public welfare agencies.

[14] *Medicaid, States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight* (p. 17), Kathryn G. Allen, Director, Health Care, Testimony Before the Committee on Finance, U.S. Senate, June 28, 2005, U.S. Government Accountability Office, at [http://finance.senate.gov/hearings/testimony/2005test/KATest

and Georgia TCM claims and found a number of claims where TCM services billed to Medicaid were integral parts of other programs, such as foster care.[15] Nevertheless, TCM expenditures continued to increase, raising questions about whether some states were delivering direct medical and social services to beneficiaries through other social services programs (e.g., child welfare, foster care, juvenile justice, special education) and classifying those expenditures as Medicaid TCM. Subsequent HHS/OIG audits found state practices for TCM claiming inconsistent with current CMS policy, federal, or state laws, and/or Medicaid rules.[16] Moreover, Bush administration officials testified that state practices for claiming TCM and other Medicaid services were abusive and violated the federal-state Medicaid partnership by inappropriately shifting costs for other federal programs to Medicaid and claiming services directly delivered by other federal programs as TCM.[17]

In 2005, Congress passed DRA, which contained Section 6052, "Reforms of the Case Management and Targeted Case Management." Sec. 6052 refined the case management definition by adding new language that narrowed what services could be considered case management. The DRA case management provision identified case management services, such as assessment, development of care plans, referral and related activities, and monitoring and followup of beneficiaries, and elaborated on the overall content of these services. The DRA also reiterated that case management, including TCM, excluded the direct delivery of underlying medical, educational, social, and other services. The DRA also specifically explained that federal matching payments would not be permitted to assist non-eligible individuals, including those individuals ineligible for a TCM target group. The DRA also reiterated that Medicaid third-party rules applied to case management, so payments for TCM would be permitted only if no other third parties are available to pay. DRA Section 6052 also specifically noted that states should cost-allocate when costs for case management services were shared between another federally funded program in accordance with OMB circular A-87. The DRA also instructed the Secretary of HHS

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[14] (...continued)
062805.pdf].

[15] See *Medicaid Financing, States Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight* (p. 19), Report to the Chairman, Committee on Finance, U.S. Senate, U.S. Government Accountability Office, June 2005, at [http://www.gao.gov/new.items/d05748.pdf].

[16] See, for example, *Iowa Medicaid Payments for Targeted Case Management for FY2003-2004* (A-07-06-03078), November 2007; *Review of Minnesota Medicaid Reimbursement for Targeted Case Management Services for FY2003-2004* (A-05-05-00059), October 2007; Department of Health and Human Services, Office of Inspector General, at [http://oig.hhs.gov/oas/oas/cms.html].

[17] As examples of abusive TCM claiming, CMS cited states' Medicaid claims for court appearances, crisis counseling, parental training, and transportation related to foster care and child welfare; see Dennis Smith's testimony to the Senate Committee on Finance hearing on Medicaid Fraud and Abuse, June 28, 2005, at [http://finance.senate.gov/hearings/testimony/2005test/DStest062805.pdf]. See also Testimony of HHS Secretary Michael Leavitt at the House Budget Committee hearing on the President's Health and Human Services FY2009 Budget, February 27, 2008, at [http://budget.house.gov/hearings.htm].

to promulgate interim final regulations to implement the case management changes. The TCM interim final rule was published on December 4, 2007.

Case Management Interim Final Rule

The case management interim final rule elaborates on changes to the TCM definition authorized and initiated in DRA by providing specific guidance on how states may claim federal financial participation (FFP) for TCM expenditures. It also directly addresses case management issues that previously might have been considered open to interpretation. CMS stipulated that the case management interim final rule applies to all Medicaid authorities, so that all case management, including TCM and services delivered through waivers, would be covered under the rule.[18] CMS estimated that the case management regulation will reduce federal Medicaid expenditures by approximately $1.28 billion between FY2008 and FY2012. CMS also estimated that federal foster care expenditures would increase by $369 million between FY2008-FY2012. Some of the changes addressed in the proposed rule are outlined below.

Institutional Care

Federal financial participation (FFP) would be paid for case management provided to individuals who reside in community settings or who want to transition from institutions to community settings. In general, states may not receive FFP for beneficiaries residing in inpatient acute care facilities, although there is an exception for individuals with complex or chronic medical needs (as defined by states). The interim final rule permits states to receive FFP to assist individuals who are able to transition from an institution to a community setting. This provision would enable states to claim FFP to assist individuals in transitioning to community settings during either the last 14 days (for beneficiaries institutionalized for short-term stays) or the last 60 days (for beneficiaries who were institutionalized for long-term stays). However, for states to receive FFP for beneficiaries transitioning to the community, the beneficiary must receive the TCM services for terms that span their inpatient and community placement. In addition, under the new regulations, FFP would be payable only after the date on which beneficiaries' community residence begins. States may use TCM to help coordinate other services, such as housing and transportation, for individuals transitioning to community settings.

State Plan Amendments (SPAs)

States that now cover case management services and want to continue to do so after March 2008 must amend their Medicaid state plans, specifying whether services are or are not targeted (and who are the target group, if applicable), the geographic area served, the kinds of case management services offered, frequency of assessments and monitoring by case managers, the qualifications of service providers, and the

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[18] TCM Regulation Summary, Minnesota Department of Human Services, January 8, 2008, at [http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/ dhs16_140351.pdf], accessed March 18, 2008.

payment methodology. States also must prepare separate SPAs for each case management target group and subgroup.

Case Managers

States need to establish qualifications for providers who will deliver case management services. In addition, the rule specifies the services case managers can provide, such as assessments to determine beneficiaries' needs, development of specific care plans, referral and related activities, and monitoring and follow-up activities. To ensure beneficiaries have a unified planning process, as well as to reduce fragmentation and maintain quality of care, states would need to assign each beneficiary only one case manager. However, case managers may not serve as gatekeepers or make medical necessity determinations. Further, beneficiaries must have free choice of all qualified case managers, and beneficiaries' access to case management can not be contingent upon use of certain providers. If beneficiaries might fit in several target groups, states must decide which target group to assign beneficiaries. The new regulations would allow for a delayed compliance date for states to transition to one case manager to provide comprehensive services to individuals.[19] Case managers may not provide direct medical and related services, unless such services are billed to Medicaid as services other than case management (e.g., rehabilitation).

Treatment Plans

Medicaid beneficiaries receiving case management services must have treatment plans. Case management excludes diagnostic testing (but testing might be covered under other Medicaid benefit categories). Case managers must maintain detailed case records that document beneficiaries' dates of service; progress toward treatment goals; units of case management delivered; timelines for services described in the treatment plan, as well as reassessment dates; and needs for coordination with case managers of other programs.

Payment to Providers of Case Management

States may not use bundled payment methodologies.[20] When case management is reimbursed on a fee-for-service basis,[21] the new rules would require states to use unit-of-time reimbursement methodologies based on time intervals of 15 minutes or

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[19] The new case management rule specifies that states are permitted the lesser of two years or one year after the close of the first regular session of the state legislature that begins after the regulation becomes final, before HHS will take enforcement action.

[20] A payment bundle might exist when more than one service is furnished during a fixed period of time or the payment is the same regardless of the number of services furnished.

[21] Fee-for-service refers to situations where providers are reimbursed for individual services rendered to beneficiaries. Medicaid beneficiaries may also be covered under capitated contracts, where a managed care organization assumes financial responsibility for all of a beneficiaries' medical and related care in exchange for a fixed monthly payment. Many states utilize managed care/capitated contracts, primarily for children and families.

less. For beneficiaries included in managed care/capitated contracts, states may not claim FFP for case management of medical services. The interim rule indicates that case management is an implicit part of managed care and capitation, and additional FFP for such case management of medical services under managed care would be considered duplicate payment. However, an exception to the managed care exclusion could be made when the case management services extend beyond the medical components of typical managed care contracts to include gaining access to educational, social, and other (non-medical) services.

Denial of FFP in Certain Situations

The interim final rule would prohibit FFP to states for the direct delivery of underlying medical, social, educational, or other services funded by other programs. DRA specifically addressed foster care, but the interim final rule would extend the rule to include other programs, such as child welfare and protective services, parole and probation, public guardianship, and special education. In addition, this FFP prohibition would apply to therapeutic foster care because these activities would be considered inherent to the foster care program and are separate from Medicaid. This provision would apply to paying for services delivered by staff of other social service agencies, but the rules would permit FFP for referral services, overseeing placements, training of workers, supervision, court attendance, and compensation for foster care patients. Moreover, the rule would prohibit FFP to states for administrative components of other programs, such as foster care, juvenile justice, parole and probation, guardianship, courts, and special education.

Financial Impact of TCM Interim Final Rule

Estimates of the financial impact of the interim final rule vary. Some argue that CMS underestimated the impact of the case management and other regulations, and that CMS is attempting to shift Medicaid costs to states.[22] CMS estimated that the TCM changes in the interim final rule will reduce federal Medicaid outlays by $1.28 billion over five years, whereas CBO estimated that the TCM provision in DRA would reduce federal expenditures by $760 million. CBO's estimate of the impact of DRA provisions was for the period FY2006-FY2010, whereas CMS's estimate was for the five year period FY2008-FY2012. In a more recent estimate for the period FY2008-FY2012, CBO forecasted that gross Medicaid outlays would decrease by $2.0 billion for the five year period, with a $1.5 billion net reduction (including effects in foster care administration) in Medicaid outlays for that time period. A survey of state Medicaid directors by the House Committee on Oversight and Government Reform estimated the financial impact of the TCM regulation to be approximately $3.1 billion over the five years from FY2009-FY2013.

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[22] See *The Administration's Medicaid Regulations: State-by-State Impacts*, United States House of Representatives, Committee on Oversight and Government Reform, Majority Staff, March 2008, at [http://oversight.house.gov/features/medicaid08].

Various Perspectives on the Interim Final Rule

There are at least three distinct perspectives on TCM policy issues: (1) the perspective of advocates representing children and adults who could receive Medicaid TCM services, (2) state governments and Medicaid agencies, and (3) the federal regulatory agency (CMS) responsible for implementing DRA and enforcing states' compliance with federal Medicaid statutes.

As CMS indicates in the interim final rule, DRA required the agency to write regulations. Specific guidance and definitions, CMS contends, were needed to avoid further "excessive" federal outlays. CMS points out that the proposed rule clarifies when Medicaid will, and will not, pay for case management services. CMS further claims the proposed rule will reduce past confusion about the overlap between Medicaid TCM and non-Medicaid programs. Moreover, CMS cites GAO studies, OIG audits, and review of SPAs that document past abuses of Medicaid TCM claiming.

Advocates for children and adult Medicaid beneficiaries who receive TCM services contend that the rule is more restrictive than what Congress intended in DRA.[23] Advocates also fear that reduced federal Medicaid funding for TCM will need to come from other programs or services that do not have funding, resulting in cuts to TCM services. States cite administrative complexities of the rule that will increase state costs while decreasing provider participation and beneficiaries' quality of care. Further, states and advocates also believe that the complexity of the rule will make it difficult for states to implement within the specified time frame.

Child welfare advocates and organizations representing mentally retarded and developmentally disabled individuals, many of whom need Medicaid TCM, believe that the interim final rule will cut TCM services for these beneficiaries. Child welfare advocates argue that by requiring Medicaid to reimburse providers based on 15-minute billing segments, costs of care would increase and provider participation would decrease. They also argue that new requirements for record keeping and claims processing will discourage provider participation and reduce actual beneficiary services. Advocates claim that states already cannot afford to fund enough TCM services and that with more restrictions, states will be forced to cut services further. According to advocates, with less TCM available, children receiving foster care and protective services will get fewer health care services, causing their existing medical and related conditions to deteriorate. Moreover, they argue, without TCM, these beneficiaries will ultimately require more costly health care treatment in the future.[24]

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[23] See First Focus, *CMS' Medicaid Regulations: Implications for Children with Special Health Care Needs*, Sara Rosenbaum, J.D., March 2008, at [http://firstfocus.net/Download/CMS.pdf].

[24] See Child Welfare League of America, Comments on Medicaid Interim Final Regulation on Targeted Case Management, February 1, 2008, at [http://www.cwla.org/advocacy/medicaid080201.htm], accessed March 19, 2008.

Some Medicaid and other state officials believe that the CMS case management rule will increase costs by creating additional administrative activities.[25] For example, Medicaid agencies have raised objections to the additional reporting requirements and other administrative complexities contained in the interim final rule because they believe these rules will make it harder for them to provide TCM to beneficiaries. Medicaid agencies claim that new delayed billing requirements for providers who assist TCM beneficiaries in transitioning from institutions are burdensome and may reduce patient access to TCM services.[26]

As noted earlier, the interim final rule proposes to permit states up to two years to comply with the one-provider provision for case management. The additional time for states to comply suggests that CMS recognizes the complexity for states to adapt their systems and administratively comply with the proposed rules. In the same vein, state Medicaid agencies believe that the effective date of the interim final rule is inadequate to permit states sufficient time to comply with the regulations, so that states' FFP for case management will be withdrawn suddenly or recovered later under auditors' disallowances.[27] Observers maintain that an extension of time for states to comply might help to moderate stakeholder concerns, while giving states the opportunity to provide an orderly transition and realistically comply with the regulations that have been under development for some time.

Legislative and Other Proposals

In January 2008, legislation was introduced (H.R. 5173 and S. 2578) that would impose a moratorium on changes to Medicaid case management services until April 1, 2009. In addition, the Indian Health Care Improvement Act Amendments of 2008 (S. 1200) was amended to delay implementation the case management interim final rule until April 1, 2009. In March 2008, the Protecting the Medicaid Safety Net Act of 2008 (H.R. 5613) was introduced in the House, which would impose moratoria until April 1, 2009, on Medicaid regulations, including TCM. The House included a provision (H.Con.Res. 312, Sec.312) establishing a budget reserve that could be used to prevent or delay implementation of TCM and other Medicaid regulations, as long as this provision was in accordance with pay-as-you-go principles. Similarly, the Senate, in the FY2009 Concurrent Budget Resolution (S.Con.Res.70, Sec.306), created budget-neutral reserve funds that could be used to impose moratoria on implementation of Medicaid rules and administrative actions affecting Medicaid.

In addition to the interim final rule, the Bush Administration's FY2009 federal budget submission proposed that legislation is needed to restrict Medicaid TCM claiming to the lower 50% rate provided for administrative activities, rather than

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[25] *New Medicaid Rules Would Limit Care for Children in Foster Care and People With Disabilities in Ways Congress Did Not Intend*, Judith Solomon, Center on Budget and Policy Priorities, December 21, 2007, at [http://oig.hhs.gov/oas/oas/cms.html].

[26] Letter to Kerry Weems, Administrator, Centers for Medicare and Medicaid Services, February 4, 2008, (p.4), from the American Public Human Services Association and its affiliate, the National Association of State Medicaid Directors, at [http://www.aphsa.org/home/doc/NASMD ltr_TCMcmntFeb408.pdf], accessed February 14, 2008).

[27] Ibid, p. 3.

federal medical assistance percentage rates for covered benefits.[28] The Administration has not offered legislation restricting TCM claiming rates yet.

Table 2. Medicaid Targeted Case Management Expenditures, Beneficiaries, and Expenditures, Per Beneficiary, FY2005

States	Expenditures	Beneficiaries	$ Per Beneficiary
Alabama	$47,079,039	28,436	$1,656
Alaska	$7,395,511	4,310	$1,716
Arizona[a]	0	0	—
Arkansas	$15,688,320	45,430	$345
California	$535,768,383	418,922	$1,279
Colorado[a]	0	0	—
Connecticut	$26,461,108	17,592	$1,504
Delaware	0	0	—
District of Columbia[a]	0	0	—
Florida	$123,073,255	85,794	$1,435
Georgia	$128,704,852	117,526	$1,095
Hawaii	$872,458	1,463	$596
Idaho	$11,844,337	10,636	$1,114
Illinois	$222,685,899	820,976	$271
Indiana	$13,143,144	13,793	$953
Iowa	$22,827,509	10,942	$2,086
Kansas	$74,943,822	21,140	$3,545
Kentucky	$22,077,584	15,233	$1,449
Louisiana	$21,983,190	14,080	$1,561
Maine	$96,493,716	35,068	$2,752
Maryland	$5,601,164	16,129	$347
Massachusetts	$221,258,249	38,294	$5,778
Michigan	$19,726,427	52,251	$378
Minnesota	$224,214,087	101,823	$2,202
Mississippi	$39,345,391	44,926	$876
Missouri	$60,530,941	39,387	$1,537

[28] In its annual budget proposals for the federal FY2009, the Bush administration proposes to limit Medicaid matching rates for TCM to 50%, the administrative matching rate. See [http://www.hhs.gov/budget/docbudget.htm].

States	Expenditures	Beneficiaries	$ Per Beneficiary
Alabama	$47,079,039	28,436	$1,656
Montana	$3,314,715	4,679	$708
Nebraska	$19,974,036	NA	NA
Nevada	$21,913,738	13,911	$1,575
New Hampshire[a]	0	0	—
New Jersey	$6,669,245	5,456	$1,222
New Mexico	$12,875,580	11,150	$1,155
New York	$210,161,965	103,755	$2,026
North Carolina	$186,068,397	143,440	$1,297
North Dakota	$4,063,820	4,565	$890
Ohio	$1,270,746	10,913	$116
Oklahoma	$47,414,174	38,959	$1,217
Oregon	$67,604,053	42,664	$1,585
Pennsylvania	$57,964,007	69,275	$837
Rhode Island	$8,052,616	9,266	$869
South Carolina	$70,833,597	50,941	$1,391
South Dakota[a]	0	0	—
Tennessee[a]	0	0	—
Texas	$184,761,615	211,513	$874
Utah	$16,810,410	7,699	$2,183
Vermont	$7,644,346	6,436	$1,188
Virginia	$1,677,454	4,023	$417
Washington	$3,606,705	4,129	$874
West Virginia	$3,875,936	8,643	$448
Wisconsin	$22,136,862	36,077	$614
Wyoming	$1,637,081	2,382	$687
United States	$2,902,049,484	2,744,027	$1,058

Source: All Medicaid expenditure data discussed in this report include both federal and state expenditures, as well as expenditures for Medicaid-expansions under the State Children's Health Insurance Program (M-SCHIP). Medicaid Statistical Information System (MSIS), FY2005, downloaded January 24, 2008. FY2004 data were used for Maine as an estimate of FY2005 data.

a. Although these states indicate they provide TCM, they did not report TCM expenditures in their FY2005 MSIS data.