

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

**ACTION REFERRAL**

TO <i>Waldrep/Mackey</i>	DATE <i>12-28-12</i>
-----------------------------	-------------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000187</i>	<input checked="" type="checkbox"/> Prepare reply for the Director's signature DATE DUE <i>1-11-13</i>
2. DATE SIGNED BY DIRECTOR <i>C: Director, COS, Roberts Betheman</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
<i>cleared 2/13/13, letter attached</i>	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			<i>Brenda's copy</i>
2.			
3.			
4.			

330

**Palmetto Association  
for Children & Families**  
*Helping Children. Serving Families.*

December 21, 2012

Mr. Anthony Keck, Director  
Department of Health and Human Services  
1801 Main Street  
Columbia, SC 29201

Re: Targeted Case Management (TCM) – Freedom of Choice

Dear Mr. Keck:

The attached Memorandum went out to DSN Boards and does not appear compliant with 42CFR 441.18 (a)(1). Since the state assured CMS that the provision of case management services would not restrict an individual's free choice of providers, this appears to violate Section 1902(a)(23) of that Act.

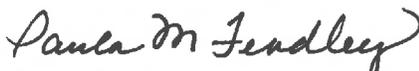
The Association has been clear that we intend for our members to be given every opportunity to deliver and bill for TCM. Child serving organizations have been making every effort to diversify away from delivering only residential services, and this clearly closes a door to delivering TCM to DSN clients.

We have the following questions:

- (1) How will state agencies (in the case DDSN) convey to the consumer that there is a list of other qualified providers from which to choose?
- (2) If the state agency has to prior authorize TCM, what assurances are there that the state agency will authorize another qualified provider to deliver the service?
- (3) How will SCDHHS monitor compliance of state agencies with the above referenced federal Freedom of Choice requirements?

Thank you in advance for your consideration of this issue. The favor of a reply is requested.

Kindest Personal Regards,



Paula M. Fendley, M. Ed., LMSW  
Chief Executive Officer

Enclosures

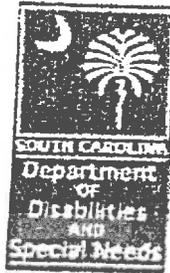
**RECEIVED**

DEC 27 2012

Department of Health & Human Services  
OFFICE OF THE DIRECTOR



Beverly A. H. Buscemi, Ph.D.  
State Director  
David A. Goodell  
Associate State Director  
Operations  
Kathi K. Lacy, Ph.D.  
Associate State Director  
Policy  
Thomas P. Waring  
Associate State Director  
Administration



3440 Harden Street Ext (29203)  
P.O. Box 4706, Columbia, South Carolina 29240  
803/898-9600  
Toll Free: 888/DSN-INFO  
Website: www.ddsn.sc.gov

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Katherine Llamas Finley  
Eva R. Ravenel

## MEMORANDUM

TO: Executive Directors, DSN County Boards  
CEOs, Contracted Service Providers

FROM: Beverly A.H. Buscemi, Ph.D., State Director *Beverly A. H. Buscemi PMO*

RE: Medicaid Targeted Case Management (MTCM)  
Service Coordination and Early Intervention

DATE: December 20, 2012

On December 19, 2012, DDSN received temporary guidance from the Department of Health and Human Services (DHHS) regarding the changes to Medicaid Targeted Case Management (MTCM) effective January 1, 2013. This temporary guidance will affect your Service Coordinators and Early Interventionists as follows:

- The attached Interim Transition Form DHHS Form 259 must be completed for all existing consumers receiving Level I Service Coordination, including children receiving it as a component of early intervention, and any new consumers who are approved for Level I Service Coordination/Early Intervention by March 31, 2013. Instructions for completing the form have been provided by DHHS and are also attached. Please note the following regarding this form:
  - Indication of "current targeted case management agency" on this form is referring to the agency enrolled with DHHS as a MTCM provider. In all cases, this would be DDSN. You will continue to complete the SC/EI choice form to indicate choice within the DDSN provider network.
  - The form requires the completion of a Freedom of Choice form (this is in addition to the SC/EI choice form). This form is also attached and must be signed by the

P.O. Box 239  
Clinton, SC 29325-5328  
Phone: (864) 938-3497

### DISTRICT I

Midlands Center - Phone: 803/935-7500  
Whitten Center - Phone: 864/833-2733

1 9995 Miles Jamison Road  
Summerville, SC 29485  
Phone: 843/832-5576

### DISTRICT II

Coastal Center - Phone: 843/873-5750  
Pee Dee Center - Phone: 843/664-2600  
Salceby Center - Phone: 843/332-4104

consumer or legal guardian. Again, this form is referring to the choice of MTCM provider that is enrolled with DHHS, so the Provider name included in the form would be DDSN (see page 2 of instructions for complete listing of providers of MTCM).

- Concurrent Case Management will no longer be a part of the MTCM program. Service Coordinators should make every effort to identify other agencies providing Case Management. During the transition, please continue to provide services and report as you have in the past.
- The \$20 and \$15 rate for MTCM has been re-defined for the transition period. The \$20 rate will be used for any face-to-face visits with the consumer. The \$15 will be used for any other MTCM encounters. The service notes system contact types will be updated to reflect this new definition by January 1, 2013.

The temporary guidance received from DHHS indicates that the MTCM provider manual will be updated and posted to the web by January 1, 2013. Once the provider manual has been updated, the DDSN SC Standards and EI Manual will be revised to reflect all new changes. DDSN is working with its provider network to develop training webinars for all services coordinators and early interventionists. I apologize that we don't have any additional information at this time, but we will continue to update you as we receive new information.

Please send any questions or comments to Ms. Janet Priest or Lori Manos.

Interim Medicaid Targeted Case Management Transition Form

**Beneficiary Identification:**

Last Name	First Name	Initial
/ /	Medicaid #	Provider Client #
Date of Birth		

**Current Targeted Case Management Provider:**

Agency Name	Phone Number
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**Mailing Address:**

Provider Contact Name and Fax Number

**Interim Beneficiary Validation or Revalidation of Existing Beneficiary:** Determine appropriate Target Group(s) and describe the beneficiary's behavior and circumstances which indicate the need/ medical necessity for Medicaid Targeted Case Management (MTCM) Services in the space below. The recommendation must be based on clinical information and the beneficiary's current situation. Attach supporting Psychiatric and/or Medical Assessment completed by Primary Care Physician, Psychological/Social Summary or discharge summary.

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**Target Groups – Circle the Appropriate Target Group(s)**

*(Target Group definitions can be found in the Targeted Case Management manual on the SCDHHS Web site: <http://provider.scdhhs.gov>.)*

- Individuals with Intellectual and Related Disabilities
- At Risk Children
- Adults with Serious and Persistent Mental Illness
- At Risk Women and Children
- Individuals with Psychoactive Substance Disorder
- Individuals at Risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Similar Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

This interim form must be maintained in the beneficiary's MTCM record and completed no later than March 31, 2013 for dates of service beginning January 1, 2013.

Interim Medicaid Targeted Case Management Transition Form

**Medical Necessity Criteria:**

- Beneficiary would benefit from a referral to services that are necessary to diagnose, treat, cure, or prevent an illness
- Beneficiary would benefit from a referral for services that would reduce, correct or ameliorate the physical, mental, developmental, or behavioral effects of an illness, injury or disability
- Assist the beneficiary to achieve or maintain sufficient functional capacity to perform age-appropriate or developmentally appropriate daily activities;
- The beneficiary, parent or caregiver is unable to provide adequate coordination of services.
- There is a lack of food, clothing, shelter, or other concrete resources that impact the health and well-being of the beneficiary.

**Current or Past Service Providers:**

List physicians, psychologist, and staff from providers such as DSS, DJJ, Continuum of Care, DDSN, Mental Health, School for Deaf and Blind, therapist, special education, Head Start, First Steps, and Drug and Alcohol treatment. Obtain signed releases and include dates of service if known.

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I recommend that the above named Medicaid beneficiary receive MTCM service(s). The beneficiary is aware that MTCM services are not required to receive Medicaid services to address identified needs.

By my signature, I attest that the beneficiary was provided an opportunity to choose from a list of enrolled Medicaid TCM providers. (Attach a copy of the signed and dated Freedom of Choice Form.)

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Case Manager's Signature

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

This interim form must be maintained in the beneficiary's MTCM record and completed no later than March 31, 2013 for dates of service beginning January 1, 2013.

## FREEDOM OF CHOICE

*This form should be completed after MTCM eligibility determinations have been made.*

I have been informed of the Medicaid Targeted Case Management (MTCM) services available to me or my child. I understand I have a right to choose the provider of Medicaid Targeted Case Management services, and I have been given the opportunity to choose between enrolled Medicaid providers in my community setting.

As long as I remain eligible for MTCM services, I will continue to have the opportunity to choose between qualified MTCM providers.

I understand that I have the right to refuse MTCM services. Refusal of MTCM services does not prevent me from receiving other Medicaid services for which I may qualify.

I agree to receive Medicaid Targeted Case Management services for

\_\_\_\_\_  
Beneficiary Name

\_\_\_\_\_  
Medicaid Number

I select \_\_\_\_\_ as my provider for MTCM Services.  
Name of Provider

I decline Medicaid Targeted Case Management Services

\_\_\_\_\_  
Beneficiary Name

\_\_\_\_\_  
Medicaid Number

\_\_\_\_\_  
Signature of recipient

\_\_\_\_\_  
Date signed (month, day, year)

\_\_\_\_\_  
Signature of: (check one) \_\_\_ Family  
\_\_\_ Guardian \_\_\_ Witness

\_\_\_\_\_  
Date signed (month, day, year)

\_\_\_\_\_  
Signature of Case Manager

\_\_\_\_\_  
Date signed (month, day, year)

DISTRIBUTION: Original – Provider Case File

Beneficiary Copy



**INTERIM MEDICAID TARGETED CASE MANAGEMENT (MTCM) TRANSITION FORM 259  
INSTRUCTIONS**

**Purpose**

The purpose of this form is to provide a process for transitioning existing clients to the new MTCM system on or after January 1, 2013 and to also accommodate any new referrals until April 1, 2013 when the prior authorization (PA) process will be in place. The form must indicate the target group and provide the appropriate documentation to support medical necessity during the transition period from January 1, 2013 through March 31, 2013. In addition to documenting the specific target group(s) and providing the required medical necessity component, the form also moves the program toward Phase II implementation which will include (PA) based on documented medical necessity reviewed by SCDHHS or a quality improvement entity. The implementation for Phase II is projected to be April 1, 2013 and will include PA and the other reforms to the MTCM program.

**Completion of transition Form 259**

The form must be completed by the case manager during the three month transition period, but no later than March 31, 2013, and placed in the beneficiary's case file. The Office of Program Integrity at SCDHHS will not audit MTCM records during this transitional period for compliance on completion of Form 259 on dates of service after January 1, 2013.

**Beneficiary Identification – self explanatory**

**Current Targeted Case Management Agency**

This contact information will be used for the (PA) Process once Phase II is implemented in order to notify the agency of the PA status.

**Interim Validation/Revalidation of Existing Beneficiary**

This section should indicate if the beneficiary is a new referral or an existing beneficiary until Phase II is operational. The form should indicate the target group and provide the appropriate documentation to support medical necessity. Examples of supporting documents are provided on the form.

**Target Groups**

Circle the arrow in the left margin to indicate the appropriate target group(s).

**Medical Necessity Criteria**

This section is used to assist the person completing the validation portion of the form on what type of information helps define the Medical Necessity Criteria and does not require annotation.

**Current or Past Service Providers**

If additional information is required to meet medical necessity, this section provides information to the PA reviewer on previous and current services being rendered. Past services would include those provided within the last 6 months to a year.

**Freedom of Choice**

As of January 1, 2013 the following providers of MTCM include:

Department of Social Services	Department of Mental Health
Department of Disabilities and Special Needs	Department of Juvenile Justice
Department of Alcohol and Other Substance Abuse	Continuum of Care
School for the Deaf and Blind	First Steps
James R. Clark Sickle Cell Foundation	

Once other providers enroll, a list of qualified Medicaid providers geographically will be maintained on the agency web site. A Freedom of Choice form is attached.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

P.Fendley@SCAOPHS.com  
ACTION REFERRAL



TO Waldrep/Macy	DATE 12-28-12
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C. Director, COS, Roberts B. [Signature]	<input type="checkbox"/> FOIA DATE DUE: _____
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APPROVALS (Only when prepared for director's signature)	APPROVE	DISAPPROVE (Note reason for disapproval and return to preparer)	COMMENT
1.			Brenda's copy
2.			
3.			
4.			



100

**Brenda James**

Log # 187 + 192 ✓

**From:** Richard Kluender  
**Sent:** Thursday, January 10, 2013 2:26 PM  
**To:** Brenda James  
**Subject:** FW: Scan from Copier

Brenda this is in addition to what I gave on the log letter listing, this is from George Maky's area.

-----Original Message-----

**From:** Margie Hickerson  
**Sent:** Thursday, January 10, 2013 2:08 PM  
**To:** Richard Kluender  
**Subject:** RE: Scan from Copier

There are only 2 that are mine.

187 - has been given to George for his completion.

192 - has been give to George, Anita, and Lenora for completion.

Thanks  
Margie

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December 21, 2012

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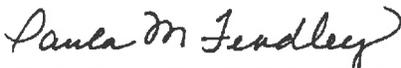
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Paula M. Fendley, M. Ed., LMSW  
Chief Executive Officer

Enclosures

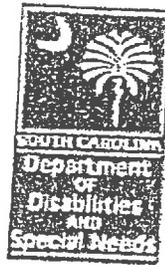
**RECEIVED**

DEC 27 2012

Department of Health & Human Services  
OFFICE OF THE DIRECTOR



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State Director  
David A. Goodell  
Associate State Director  
Operations  
Kathi K. Lacy, Ph.D.  
Associate State Director  
Policy  
Thomas P. Waring  
Associate State Director  
Administration



3440 Harden Street Ext (29203)  
P.O. Box 4706, Columbia, South Carolina 29240  
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Toll Free: 888/DSN-INFO  
Website: www.ddsn.sc.gov

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Katherine W. Davis  
Harvey E. Shiver  
Katherine Llamas Finley  
Iva R. Ravenel

## MEMORANDUM

TO: Executive Directors, DSN County Boards  
CEOs, Contracted Service Providers

FROM: Beverly A.H. Buscemi, Ph.D., State Director *Beverly A. H. Buscemi, Ph.D.*

RE: Medicaid Targeted Case Management (MTCM)  
Service Coordination and Early Intervention

DATE: December 20, 2012

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### DISTRICT II

Coastal Center - Phone: 843/873-5750  
Pee Dee Center - Phone: 843/664-2600  
Salceby Center - Phone: 843/332-4104



Interim Medicaid Targeted Case Management Transition Form

**Beneficiary Identification:**

\_\_\_\_\_

Last Name
First Name
Initial

\_\_\_\_/\_\_\_\_/\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_

Date of Birth
Medicaid #
Provider Client #

**Current Targeted Case Management Provider:**

\_\_\_\_\_

Agency Name
Phone Number

\_\_\_\_\_

Mailing Address:

\_\_\_\_\_

Provider Contact Name and Fax Number

**Interim Beneficiary Validation or Revalidation of Existing Beneficiary:** Determine appropriate Target Group(s) and describe the beneficiary's behavior and circumstances which indicate the need/ medical necessity for Medicaid Targeted Case Management (MTCM) Services in the space below. The recommendation must be based on clinical information and the beneficiary's current situation. Attach supporting Psychiatric and/or Medical Assessment completed by Primary Care Physician, Psychological/Social Summary or discharge summary.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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I understand that I have the right to refuse MTCM services. Refusal of MTCM services does not prevent me from receiving other Medicaid services for which I may qualify.

I agree to receive Medicaid Targeted Case Management services for

\_\_\_\_\_  
Beneficiary Name Medicaid Number

I select \_\_\_\_\_ as my provider for MTCM Services.  
Name of Provider

I decline Medicaid Targeted Case Management Services

\_\_\_\_\_  
Beneficiary Name Medicaid Number

\_\_\_\_\_  
Signature of recipient Date signed (month, day, year)

\_\_\_\_\_  
Signature of: (check one) \_\_\_ Family  
\_\_\_ Guardian \_\_\_ Witness Date signed (month, day, year)

\_\_\_\_\_  
Signature of Case Manager Date signed (month, day, year)

DISTRIBUTION: Original – Provider Case File

Beneficiary Copy



**INTERIM MEDICAID TARGETED CASE MANAGEMENT (MTCM) TRANSITION FORM 259  
INSTRUCTIONS**

**Purpose**

The purpose of this form is to provide a process for transitioning existing clients to the new MTCM system on or after January 1, 2013 and to also accommodate any new referrals until April 1, 2013 when the prior authorization (PA) process will be in place. The form must indicate the target group and provide the appropriate documentation to support medical necessity during the transition period from January 1, 2013 through March 31, 2013. In addition to documenting the specific target group(s) and providing the required medical necessity component, the form also moves the program toward Phase II implementation which will include (PA) based on documented medical necessity reviewed by SCDHHS or a quality improvement entity. The implementation for Phase II is projected to be April 1, 2013 and will include PA and the other reforms to the MTCM program.

**Completion of transition Form 259**

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**Beneficiary Identification – self explanatory**

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**Interim Validation/Revalidation of Existing Beneficiary**

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If additional information is required to meet medical necessity, this section provides information to the PA reviewer on previous and current services being rendered. Past services would include those provided within the last 6 months to a year.



SC Department of Health and Human Services  
Transmittal for Director's Signature

Item(s) to be signed: Log Letter **187**

Indicate reason Director's signature is needed: Agency Policy

DATE REQUESTED BY:	CONTACT PERSON & PHONE #:
ASAP	Margaret Hopkins <b>898-3021</b>

**APPROVALS**

1) DIVISION DIRECTOR/BUREAU CHIEF SIGNATURE: Brenda Hyleman <b>BH</b>	Date: <b>1-16-13</b>
2) DEPUTY DIRECTOR'S SIGNATURE: Sam Waldrep	Date:
3) OTHER (Please indicate) <b>mt</b> Margaret Hopkins	Dates: <b>01/15/13</b>
	Dates:
	Dates:

**FOR DIRECTOR'S USE ONLY**

DATE RETURNED:	___ APPROVED ___ DISAPPROVED
----------------	------------------------------





February 13, 2013

Paula M. Fendley, M. Ed., LMSW  
Chief Executive Officer  
Palmetto Association for Children and Families  
133 Powell Drive  
Lexington, South Carolina 29072

**SUBJECT:** Medicaid Targeted Case Management Freedom of Choice

Dear Ms. Fendley:

Thank you for your letter dated December 21, 2012 in which you notified the South Carolina Department of Health and Human Services (SCDHHS) about concerns in the letter from the South Carolina Department of Disabilities and Special Needs with instructions to their providers on the issue of Freedom of Choice in the Medicaid Targeted Case Management (MTCM) program. SCDHHS issued a letter dated December 19, 2012 to existing MTCM providers with instructions on the process for transitioning clients from previous target groups, validating medical necessity, and documenting eligibility of new clients. Please see below under bold headers language that was shared with all providers.

**Interim Transition Form DHHS Form 259**

"The form should be used during the transition period from January 1, 2013 through March 31, 2013 to designate the target group and provide the appropriate documentation to support medical necessity." Instructions on how to complete the form were requested at the state agency meeting Friday and are attached to this letter. In addition to documenting the specific target group(s) and providing the required medical necessity component, the form also moves the program toward Phase II which will include prior authorization (PA) based on documented medical necessity criteria to be reviewed by PA staff. Please be advised that Phase II is planned for implementation and will include PA and the other reforms to the program. Form 259 will be replaced with a PA form which will contain similar information.

**Freedom of Choice**

Effective January 1, 2013 eligible beneficiaries will have free choice of any qualified MTCM provider. Until additional providers are enrolled, the choices will be limited to existing providers. A list of qualified Medicaid providers geographically will be maintained on the SCDHHS agency web site.

**Phase II of MTCM**

Staff will accept questions and comments on the PA process until February 15, 2013 from the state agency MTCM workgroup and other interested parties; however, after that time, no other comments will be accepted to give staff ample time for the projected implementation.



Paula M. Fendley, M.Ed., LMSW  
February 13, 2013  
Page 2

In response to your questions please note the responses.

Question 1: How will state agencies (in this case DDSN) convey to the consumer that there is a list of other qualified providers from which to choose?

Response: Agencies were informed that Freedom of Choice must be presented to the beneficiary during the transition process. The current list of enrolled TCM providers was included. Agencies have been informed that as private providers are enrolled, DHHS would maintain the updated list on the SCDHHS website.

Question 2: If the state agency has to prior authorize TCM, what assurances are there that the state agency will authorize another qualified provider to deliver service?

Response: Medicaid Targeted Case Management services will be prior authorized. Acknowledging that state agencies have been the primary provider of these services for decades, SCDHHS has explored alternative options for having these services prior authorized by a neutral entity. During Phase II of MTCM, a final method will be selected along with policy and procedure for the prior authorization and medical necessity process.

Question 3: How will DHHS monitor compliance of state agencies with the above referenced federal Freedom of Choice requirements?

During the transition period, the Freedom of Choice form will be placed in the beneficiary's record. This form will become a part of post payment reviews and quality assurance reviews. SCDHHS has not ruled out the use of Client Satisfaction surveys.

Thank you for bringing this issue to our attention. Your questions and concerns will serve as a reminder to expand or clarify federal requirements that are written into law(s) that have impact on the integrity of the Medicaid program.

Sincerely,



Sam Waldrep  
Senior Advisor

SW/hhk

cc: Pete Liggett, SCDHHS

