FREQUENTLY ASKED QUESTIONS
TARGETED SERVICES MANAGEMENT BULLETIN

QUESTION:	ANSWER:
Individual must be residing in a community setting, be eligible for Medical Assistance (MA) and have Intellectual Disability (ID) diagnosis in order to bill for Targeted Services Management (TSM) so that excludes individuals in Residential Treatment Facilities (RTF), correct?	This was an oversight; bulletin should read, "Be residing in a waiver eligible setting".
Do TSM providers have the right to refuse TSM individuals (mostly due to lack of available personnel)? The bulletin states on page 2 "The county MH/ID Program is responsible for informing individuals of their right to choose willing and qualified TSM providers".	Providers are prohibited from denying services or otherwise discriminating against an MA recipient on the grounds of race, color, national origin or handicap. In the example given, the TSM Provider would be required to document that lack of personnel is the reason for denying the referral in accordance with Supports Coordination Services, ODP Bulletin 00-16-10.
Page 2 states "An individual who is enrolled in a 1915(c) wavier may not receive TSM as he or she receives supports coordination through the Waiver". So if an individual is enrolled in a 1915(c) waiver that is NOT an ODP waiver (such as Independence or OBRA) and is not technically TSM eligible – can the TSM Provider do an abbreviated plan?	Supports Coordination activities are not reimbursable under TSM therefore you should follow the Individual Support Plan (ISP) guidance in the ISP Manual. For Base funded SC Services, please consult with your County MH/ID Program.
If I am reading correctly, TSM is not billable for ID enrolled individuals if they are enrolled in non-ID waivers such as aging or attendant care etc. Please confirm. For example, we have a few individuals who are TSM eligible enrolled in the Aging waiver.	Correct. If an individual is enrolled in any 1915(c) Medicaid Waiver, TSM cannot be billed.
If a meeting/billing activity includes staff from other program offices can each represented Program office bill for their services? (Ex: if there is representation from ODP ID and MH and one is coordinating and the other is monitoring, can both bill for their attendance and contribution to the meeting/discussion?)	55 Pa. Code 1247, relating to target case management service has section 1247. 53 (b), relating to limitations of payment, which states, "Payment will be made for targeted case management services provided by only one MA case manager per recipient for a given period of time.

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QUESTION:	ANSWER:
How do AEs verify an individual's enrollment in a 1915c waiver other than Con/PFDS (other than looking up each individual record) for Base monies payment?	The AE will have to verify by looking at information in the individual record.
What is meant by the term, "initial assessment"? Is it the ISP?	No, the initial assessment is not the ISP. The ISP identifies information about the individual and summarizes all assessment results. Please refer the ISP manual, section 2.3 Assessment process that details ODPs requirements regarding formal and informal assessments.
Is there a standardized assessment tool or does "assessment" refers to the process of identifying needs when a case is opened and annually at the ISP meeting?	*Assessment* refers to the process of identifying needs when a case is opened and annually at the ISP meeting. Currently, there is not a single standardized tool.
Page 3 of the bulletin (1st paragraph) states "TSM providers are required to ensure an initial assessment has been completed within 45 days of referral to the TSM agency and at least annually thereafter or sooner if there is a significant change in need". SCOs would like a clarification on what referral means. They want to know if it is the date the AE presses the button in HCSIS and sends the information to the SCO or the date when the SCO accepts the new individual in HCSIS.	Referral is when the County sends the individual's information to the TSM Provider. The 45 day starts when the TSM Provider accepts the referral in HCSIS.
A lot of families go through the intake then do not complete the follow through with the TSM provider. How do we determine being out of compliance with the 45 days if the family is non-cooperative?	The targeted services manager must document all activities in service notes so there is a record of attempts that would explain the circumstances exceeding the 45 day requirement.
Page 3 of the bulletin says a full ISP must be completed at the individual's next annual planning meeting but then it also says that full ISPs must be completed and approved no later than 4/30/16—this seems to be contradictory given the bulletin was just issued on 1/20/16. Is there any wiggle room with this since bulletin just issued?	They are not contradictory requirements. The requirement was released in the ISP Bulletin and ISP Manual on May 15, 2015 which states for individuals currently receiving Targeted Service Management, a full ISP must be completed at the next annual meeting. Full ISPs were to be completed and approved no later than April 30, 2016.

QUESTION:	ANSWER:
Consent to receive TSM is done by signing the ISP Signature Form to be signed at the conclusion of the ISP mtg. Can there be a retroactive date used on this consent form to cover the phone calls and preparing for the initial assessment/ISP meeting that occurred before the ISP meeting?	Signed consent is required however TSM activities can occur and be billed prior to signed consent.
Does billing for transition services apply to people who are in Waiver or just Base and SCO consumers?	The 180 day language only applies to individuals who are MA eligible and not enrolled in a waiver. If the person is in the waiver and for some reason is placed at a nursing home or hospital for less than 30 days, the SC would bill the waiver for activities conducted that fall under locate, coordinate and monitor. If the individual is still in the NH or Hospital after day 30, the person is no longer eligible for the waiver (the person will be in reserve capacity status) but still MA eligible. Therefore, TSM can be billed for transition activities.
Are SC's required to complete a monitoring tool for individuals not in the waiver when they complete the face-to-face visit outside of the ISP meeting as per the new TSM requirements?	Yes, the targeted service manager must document the face-to-face monitoring on ODP's designated monitoring tool and enter it into HCSIS.
For minors, can the monitoring occur at the school or does the surrogate/parent need to be present?	It is best practice for the surrogate/parent to be present. ODP recommends that the monitoring be scheduled at a time and location that is accommodating for the surrogate/parent to be present. If there are circumstances that the surrogate/parent cannot be present or, if there are specific reasons that it may be necessary to monitor without a surrogate/parent present, this should be explained in service notes.

QUESTION:	ANSWER:
What is the process for SCOs back billing for the 180 days transition activity?	Updates were made in both PROMISe™ and HCSIS to support ODP's identification of TSM activities that relate to transitioning individuals to a home and community based setting. Please reference ODP Communication 036-16 "Preparations for the Fiscal Year 2016-2017 ISP Renewal Period" for further details.
If someone is in ODP waiver reserved capacity can ID SC be paid thru TSM/Promise for SC services?	Yes, as long as the individual meets the TSM eligibility requirements.
What tools, reports, extracts will there be to assist AEs in verifying the appropriate, responsible payment for each eligible encounter?	At the end of 2015, a HCSIS service note extract report was made available to AEs and SCOs that can be used to assist with verifying appropriate, responsible payment for each eligible encounter.
We reviewed the new TSM bulletin but were still unsure if the SC would be able to bill for the transition planning since the person was in an RTF. Can you provide some guidance on this situation?	Money Follows the Person (MFP) funds should be used when available for individuals transitioning from an inpatient facility (including public or private ICFs/ID, Skilled Nursing Facility, or Psychiatric Rehabilitation Treatment Facility) to an waiver funded eligible community setting. Please refer to ODP Announcement 018-16 entitled "Provider Startup and Supports Coordination Transition Funding Available Through the MFP Initiative and to Support the Movement of Benjamin Class Members" and attachment #3 of the TSM Bulletin that provides a comparison chart regarding transition activities covered through TSM and MFP.

QUESTION:	ANSWER:
What is meant by, "ISP should include provision of TSM activities." What is ODPs expectation for how TSM services are reflected in the individual's plan? And how is that to be monitored?	TSM must be documented in the ISP like any other service. It can be anywhere throughout the ISP such as, Know and Do, Important To and Important For, and in the Outcome Actions Section under what actions are needed, Who's Responsible, and Frequency and Duration. Monitoring of TSM will be conducted in the same manner as ODP SCO monitoring.
Please clarify the following language from attachment 4: *assist individuals with enrollment in a waiver, as applicable;*	Assistance by the targeted service manager with waiver enrollment activities such as but not limited to information sharing on what a waiver is, what services are provided through the waiver(s), or how the waiver enrollment process works.