

## Custodial Care Transitional Policy (CCTP)

Issue Date: June 11, 2002

Authority: 10 USC 1074 j(b)(4), 10 USC 1072 (8) and (9); [32 CFR 199.2](#)

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### 1.0 BACKGROUND

**1.1** The CCTP program came into existence following the enactment of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2002, which made a number of important changes to the TRICARE Program.

**1.2** Congress changed the definition of custodial care (10 USC 1072 (8) - (9)). Effective December 28, 2001, custodial care is no longer defined by the condition of the patient but by the type of services being rendered. Additionally, Section 701 of the NDAA for FY 2002 established the TRICARE sub-acute care program under 10 USC 1074j adding the TRICARE Skilled Nursing Facility (SNF) and Home Health Care (HHC) (i.e., the Home Health Agency (HHA)) benefits, as well as the TRICARE Extended Care Health Option (ECHO) Program under 10 USC 1079(d)-(f).

**1.3** The CCTP program was developed to cover new cases of custodial care beneficiaries entitled to expanded benefits arising on or after the effective date of the law (December 28, 2001), because the new cases could no longer be addressed under the repealed law authorizing the Individual Case Management Program (ICMP), as discussed in [Chapter 1, Section 10.1](#). The purpose of the CCTP program was to provide in-home medically necessary skilled services until eligible beneficiaries could be covered under the permanent TRICARE sub-acute care benefit and/or ECHO.

**1.4** As these new programs were being implemented, Section 713 of the NDAA for FY 2005 authorized continued benefits under CCTP, for such time period as determined appropriate, for those eligible beneficiaries who were receiving CCTP benefits before establishment of the sub-acute programs and who continued to need in-home medically necessary skilled care exceeding the otherwise authorized TRICARE Basic Program coverage. Once a beneficiary's care needs can be met by the TRICARE Basic Program HHA benefit which provides part-time or intermittent home health care services, the beneficiary is no longer eligible for CCTP.

**1.5** This transitional policy provides TRICARE coverage of medically necessary skilled services to those severely disabled beneficiaries remaining in the initial CCTP population (before the start of the TNEX contracts) that continue to receive extensive home health care services under CCTP and will remain in effect as indicated herein. CCTP is not open to new enrollees.

## 2.0 POLICY

Requirements for continued payment of CCTP benefits:

### 2.1 Eligibility

The beneficiary must be TRICARE eligible. CCTP benefits are payable for eligible beneficiaries (severely disabled beneficiaries remaining in the initial CCTP population) who meet the custodial care definition and who require in-home medically necessary skilled services beyond what is provided by the HHA Prospective Payment System (PPS) under the TRICARE Basic Program as specified in the TRICARE Reimbursement Manual (TRM), [Chapter 12](#).

### 2.2 Authorized Beneficiaries

Only those beneficiaries receiving services under the CCTP prior to the implementation of the TRICARE HHA PPS benefit in 2004 are eligible for continued coverage, specifically:

- Active Duty Family Members (ADFM)s, retirees and Non-Active Duty Family Members (NADFM)s who were receiving medically necessary services through the CCTP, as of the start of the TNEX contracts, and remain enrolled at the start of health care delivery under the new TRICARE Managed Care Support (MCS) contracts.
- ADFM)s who are eligible for the CCTP program but are enrolled in and receiving benefits through the ECHO, including ECHO Home Health Care (EHHC), remain eligible for CCTP benefits as long as the beneficiary continues to meet the custodial care definition and requires medically necessary skilled services beyond what is provided by HHA PPS under the TRICARE Basic Program.
- NADFM)s who were eligible for CCTP as ADFM)s prior to their sponsor's retirement, including those who were enrolled in and receiving benefits through the ECHO and/or EHHC while ADFM)s, remain eligible for CCTP.
- ADFM)s and NADFM)s (as described above) who become Transitional Survivors or Survivors, as those terms are used in [Chapter 10, Section 7.1](#), remain eligible for the CCTP.

**Note:** If a beneficiary's care needs can be met by the TRICARE Basic Program HHA benefit which provides part-time or intermittent home health services, the beneficiary is no longer eligible for CCTP.

### 2.3 Custodial Care

Beneficiaries must continue to meet the TRICARE definition of custodial care in effect prior to December 28, 2001, that is, custodial care is care rendered to a patient who:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged; and
- Requires a protected, monitored, or controlled environment whether in an institution or in the home; and

- Requires assistance to support the activities of daily living; and
- Is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary that would improve function to enable the patient to function outside the protected, monitored, or controlled environment.

## 2.4 Authorized Services

**2.4.1** The care authorized under this policy is specifically limited to medically necessary skilled services provided in the home and coded with the **CT** designation. Claims for other services shall be processed under normal TRICARE rules.

**2.4.2** The approved services are based on medical needs and medical needs should not change significantly from day to day or week to week without a reassessment of those medical needs. Additionally authorized but not used care periods or portions thereof, cannot be saved or accumulated for future use.

## 2.5 Annual Eligibility Reviews

Continuation of receipt of services requires reassessment on a regular basis. Managed Care Support Contractors (MCSCs) shall submit a "custodial care reassessment letter" annually to the Defense Health Agency (DHA) Director, DHA or designee.

**2.5.1** The custodial care reassessment review must demonstrate that the beneficiary:

- Is disabled mentally or physically and that such disability(ies) is (are) expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment;
- Requires assistance to support the Activities Of Daily Living (ADL) as defined in 32 CFR 199.2, which consists of providing food (including special diets), clothing, and shelter; personal hygiene services; observation and general monitoring; bowel training or management (unless abnormalities in bowel function are of a severity to result in a need for medical or surgical intervention in the absence of skilled services); safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and such other elements of personal care that reasonably can be performed by an untrained adult with minimal instruction or supervision. Activities of daily living may also be referred to as "essentials of daily living"; and
- Is not undergoing a plan of care which includes specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

**Note:** A program of physical and mental rehabilitation which is designed to reduce a disability is not custodial care as long as the objective of the program is a reduced level of care.

**2.5.2** The MCSCs will provide supporting clinical documentation of all authorized participant's medically necessary skilled services, to include a plan of care signed by the attending physician. MCSCs shall provide a complete clinical documentation update and recommendation for continuation of coverage at the same level or indicate if either an increase or decrease in services is indicated by the beneficiary's current needs. The recommendation shall also include cost-effective strategies to meet the beneficiary's needs and to ensure the appropriate level of care is delivered to include projected costs based on the number of skilled nursing hours and the rate obtained for those hours. Once DHA reviews the reassessment and updated recommendations of the MCSC, the TRICARE Clinical Support Division (CSD) will indicate concurrence or non-concurrence with the MCSC's determination that the beneficiary meets the custodial care definition under [paragraph 2.3](#), and a revised or updated authorization for continued coverage will be issued to the MCSC.

- Communication related to annual assessment or condition changes should be made through secure modalities, which can include email, fax, scanned document, and/or electronic storage devices.
- MCSC is responsible for administrative oversight of authorized medically necessary in-home skilled services in accordance with current MCS contract. This includes review of CCTP program claims for quality of care and appropriate utilization as required for all TRICARE health care claims. In addition, reviews by both the DHA and the MCSCs shall be periodically conducted to ensure that skilled services are provided in accordance with established program requirements for medically necessary and appropriate care and that hours of skilled services are being utilized in accordance with the plan of care as approved. Approved hours are designed to meet the medically necessary in-home skilled service needs of CCTP-eligible beneficiaries. There is no authority under CCTP to provide respite or custodial care. Consequently, "banking" or "saving" hours under the program, by foregoing authorized hours of medically necessary in-home skilled services, in order to provide continuous coverage (in excess of the hours of medically necessary skilled services) while family caretakers are out of town or otherwise unavailable is not permitted. Authorized but unused hours may not be saved or accumulated for any future use that is inconsistent with CCTP authorized services.

**2.5.3** For ADFMs who remain in the CCTP and whose in-home medically necessary skilled services are provided under CCTP instead of ECHO EHHC, the contractor's annual assessment shall include a determination that the fiscal year financial cap established in accordance with [Chapter 9, Section 15.1](#) will not support the level of care required. CCTP beneficiaries are eligible to utilize ECHO and ECHO EHHC during the sponsor's active duty status, if these programs meet the medical needs of the beneficiary. Beneficiaries maintain their enrollment in CCTP for life as long as they continue to meet the eligibility requirements stated under [paragraph 2.2](#).

**2.5.4** When the Director, DHA, or designee, does not concur with the custodial care determination, the beneficiary is disenrolled from CCTP and the MCSC shall process subsequent claims for medical necessary in-home skilled services under the TRICARE Basic Program HHA in accordance with the current MCS contract.

## 2.6 Portability

The Director, DHA or designee's decision regarding the custodial care determination is transferable between TRICARE Regions, that is, the "receiving" MCSC will accept the current decision of the Director, DHA or designee and proceed to process claims accordingly. ADFMs who relocate between annual assessments will be assessed by the receiving contractor for determination of whether the EHC rather than the CCTP benefit can meet the beneficiary's needs.

## 2.7 Revisions

If at any time a MCSC determines a need for a change in authorized services for a beneficiary (e.g., due to a change in CMAC rates, a change in patient condition, such as a need for more or fewer covered hours, a change in HHA, etc.) the MCSC must submit a written request for such change to the Director, DHA CSD, or designee, that includes a detailed explanation of why the change is required. The DHA CSD, or designee, will evaluate each request and provide a written decision to the MCSC.

## 2.8 Cost-Shares

Cost-shares shall not be applied to services authorized under this policy.

## 2.9 Appeals

**2.9.1** Appeals should be made directly to the DHA Appeals and Hearings Division. There are two appealable issues related to CCTP:

- A custodial care determination under [paragraph 2.3](#); and
- Types and extent of skilled services authorized for a CCTP eligible beneficiary.

**2.9.2** The following language is to be included by the MCSCs in the annual determination of custodial care and notification of benefits related to CCTP letters that are sent to beneficiaries:

"You may appeal the custodial care determination as well as the denial of in-home skilled services authorized under CCTP. Appealable issues include the types and extent of services and supplies authorized under CCTP and the determination that the care is custodial. The request must be in writing, be signed, and must be postmarked or received by the Appeals and Hearings Division, Defense Health Agency, 16401 East Centretch Parkway, Aurora, Colorado 80011-9066, within 90 days from the date of this determination. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service."

**2.9.3** The MCSC is required to issue a letter of custodial care determination to each CCTP beneficiary annually outlining the hours of skilled in home care approved for the upcoming year.

## 2.10 Claims Processing

CCTP claims are to be paid as non-underwritten health care and should be reported as such. TED records for these claims must reflect both special processing codes **CT** and **W**. Claims for

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services that are provided outside of this policy must be processed in accordance with the TOM, the TRM, and the TRICARE Systems Manual (TSM), and without the use of the special processing codes **CT** and **W**.

**2.11** MCSCs shall notify the Director, DHA CSD, or designee upon any of the following changes to any beneficiary who is covered under this policy:

- Death;
- Eligibility status, including becoming a Transitional Survivor or a Survivor as those terms are used in [Chapter 10, Section 7.1](#);
- Residential relocation (pending or completed);
- Custodial care status (as defined in [paragraph 2.3](#));
- Inpatient admission;
- Requests for disengagement.

### **3.0 EXCLUSIONS**

**3.1** Custodial care, as defined in [32 CFR 199.2](#), is not a TRICARE benefit. The term "custodial care" means treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that:

- Can be rendered safely and reasonably by a person who is not medically skilled; or
- Are designed mainly to help the patient with the Activities of Daily Living (ADL).

**3.2** CCTP benefits may not be extended for or credited towards institutional care, including assisted living facilities.

**3.3** Beneficiaries who were receiving benefits under the [Individual Case Management Program For Persons With Extraordinary Conditions \(ICMP-PEC\)](#) as of December 27, 2001, and those grandfathered under the former HHC/[Case Management \(CM\)](#) demonstration project will continue to receive those services as grandfathered members of those programs, and will not be considered for the CCTP.

### **4.0 EFFECTIVE DATE**

December 28, 2001.

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