

# Community Living Exchange Collaborative: A National Technical Assistance Program

---

*Funded by Centers for Medicare and Medicaid Services (CMS)*



**Rutgers** Center for  
State Health Policy  
Susan Reinhard, RN, PhD



Robert Mollica, EdD

## Policy Brief

### Money Follows the Person Demonstration: Covering Case Management Services

Prepared by:  
**Robert L. Mollica**  
National Academy for State Health Policy

September 2007 (revised)

*Strategic Partners:*

Roger Auerbach, Auerbach Consulting, Inc.  
NCB Development Corporation

*In collaboration with:* Independent Living Research Utilization (ILRU)

# Money Follows the Person Demonstration: Covering Case Management Services

## Background

The Centers for Medicare and Medicaid Services awarded Money Follows the Person (MFP) demonstration grants 31 states in 2007. Supporting individuals in institutions to move to the community is a critical component of MFP programs. Transition coordination, relocation coordination, supports coordination and case management are terms often used to describe this complex activity. There are five options states may use to cover under Medicaid:

- Targeted case management services;
- 1915 (c) home and community based waivers;
- Administrative activity;
- A component of another Medicaid service eg., home health; and
- 1915 (b) freedom of choice waivers.

The first three options are relevant to MFP Demonstration programs under current Medicaid policy. Changes to the CMS policy on coverage of case management are being considered. If the changes are issued and they limit or prohibit Medicaid coverage of case management, the DRA potentially makes two additional options available under the demonstration – coverage as a demonstration service or a supplemental service.

## 1. Optional targeted case management services

Targeted case management (TCM) is defined as “services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational and other services.” TCM may be furnished to nursing home residents who are preparing to move to the community. Like the 1915 (c) waiver, TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay. States may specify a shorter time period or other conditions under which targeted case management may be provided.

States must identify a target group to receive services such as nursing home residents planning to move to the community. States may include limitations in comparability (TCM will not be available in the same amount, scope and duration to all eligible recipients) and statewideness (TCM may be limited to specific geographic areas of a state). Medicaid recipients must be given a choice of TCM providers who meet the state's qualifications. However, with regard to target groups that consist entirely of persons with developmental disabilities, or individuals with chronic mental illness, the state may limit the providers of TCM to ensure that case managers are capable of ensuring that needed services are actually delivered to these vulnerable populations.

TCM became controversial over the past five years. The HHS Office of the Inspector General issued several reports and audits that found what it described as inappropriate uses of TCM in

which states claimed FFP for services to children in foster care that should have been covered by other programs.

The Deficit Reduction Act of 2005 (DRA) included additional language on the activities that may and may not be covered under case management. The Congressional Budget Office Cost Estimate of the DRA said:

“Medicaid allows states to cover case management services that help recipients obtain access to medical, social, and other services and permits states to target those services to specific populations, such as disabled adults. However, current law provides little guidance as to the specific types of services that Medicaid will cover, and some states have billed the program for services that are core elements of other programs, such as juvenile justice and foster care. The act would clarify that case management services must help recipients gain access to needed medical, social, educational, and other services and would specify that Medicaid will not cover services that are normally provided under other programs (including certain activities provided by foster care programs).

The DRA clarified the activities that could be covered under case management. The Conference Report added the basic definition: case management services in federal law are services that will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services including:

- Assessment of an eligible individual to determine service needs by taking a client history, identifying an individual’s needs and completing related documentation, and if needed, gathering information from other sources;
- Development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual’s needs;
- Referral and related activities to help an individual obtain needed services; and
- Monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual’s needs.”

The conference report further states that “those activities that are not reimbursable as case management services including the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. With respect to the direct delivery of foster care services, case management would not include research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.”

CMS is preparing regulations that will implement the DRA. While the guidance included in a State Medicaid Directors Letter issued in July 2000 supports the use of TCM to support individuals who want to relocate from an institution to the community, some states report being cautioned that TCM state plan amendments will receive greater scrutiny than in previous years and other options may be approved more quickly. Until the regulations are issued, states might consider covering case management as an administrative activity and submit a state plan

amendment at a later date. However, TCM remains a viable approach to cover relocation activities.

## **Advantages**

- States may define nursing home residents as a target population.
- Case management activities may be paid by the state to the provider prior to the date the individual becomes a waiver participant.
- States may claim FFP for case management activities prior to the individual leaving the nursing home and becoming a waiver participant.
- The individual need not be enrolled in a waiver for the state to claim FFP. Deinstitutionalization is all that is needed.
- States may also choose to provide targeted case management to individuals who are enrolled in HCBS waivers.

## **Disadvantages**

- State plan amendments may be delayed until regulations implementing the DRA changes are issued.
- States may not limit access to providers of case management services, except as specified above for individuals with developmental disabilities or chronic mental illness.

## **2. 1915 (c) home and community based services waivers**

The Medicaid manual describes case management as an “activity which assists individuals in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained.” Case management services may be used to locate, coordinate, and monitor necessary and appropriate services and may be used to encourage the use of cost effective medical care by referrals to appropriate providers and to discourage over utilization of costly services such as emergency room care for routine procedures. Case management services may also serve to provide necessary coordination with providers of non-medical services, such as local education agencies or department of vocational rehabilitation, when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which he or she might be eligible.

Case management services can be delivered to residents up to 180 consecutive days prior to discharge from a nursing home. The assessment, functional determination and preliminary plan of care can be completed while the person is still in the nursing home. This flexibility avoids creating a gap between the person’s move to the community and the initiation of services. Federal financial participation (FFP) may only be claimed by the state Medicaid agency on the date the person leaves the institution and is enrolled in the waiver. Further details are included in the Olmstead III State Medicaid Directors Letter dated July 25, 2000. Costs incurred prior the date of waiver enrollment are claimed as a special single unit of transitional case management.

Limitations on waiver enrollment effect how many people may receive case management. States with waiting lists would be limited in helping people move unless supports are available from another source. However, case management may only be claimed in the individual is enrolled in the waiver after discharge and is receiving at least one waiver service.

### **Advantages**

- Case management services are reimbursed at the state's Federal Medicaid Assistance Percentage (FMAP) rather than the administrative rate which may be lower than the FMAP.
- Case management activities include arranging, coordination and helping to arrange access to services that are not covered by Medicaid such as housing and food stamps.
- Case management activities may be provided (reimbursed) up to 180 days prior to the date the person becomes a waiver participant.
- States may establish qualifications for providers of case management services to people in nursing homes that includes prior experience serving this population.

### **Disadvantages**

- States may not limit providers of case management to a single individual or entity. Consumers must have a choice of providers of case management services.
- Reimbursement may be claimed<sup>1</sup> only when the person becomes a recipient of waiver services.
- Case management services provided to nursing home residents who do not leave the nursing home cannot be reimbursed.
- States that have a waiting list for waiver services would not be able to claim FFP for waiver case management services provided to a person who was able to move because other supports were available but did not use Medicaid waiver services. Targeted case management services and administrative case management would be available to these persons.

### **3. Administrative activity**

Case management may be reimbursed "as a function necessary for the proper and efficient operation of the Medicaid State plan." The payment rate is either the 50 percent matching rate or the 75 percent FFP rate for skilled professional medical personnel, who are employed in State or local agencies other than the Medicaid agency who perform duties that directly relate to the administration of the Medicaid program. As an administrative activity, case management must be related to covered Medicaid services and do not cover gaining access to other services such as housing, food stamps or other non-Medicaid services.

In cases where workers perform activities funded under multiple auspices, careful records must be kept to document the State's claims for Federal funds under the appropriate authorities.

---

<sup>1</sup> Case management services may be delivered prior to enrollment in the waiver but FFP may not be claimed until enrollment.

Administrative case management activities may be performed by an entity other than the single State agency. However, there must be an interagency agreement in effect.

When a State expects to claim FFP for Medicaid administrative case management activities, the costs for these activities must be included in a cost allocation plan submitted to and approved by the CMS regional office.

### **Advantages**

- States may limit providers of case management activities which may be important in states that use single entry point agencies to facilitate access to services.
- Services may be claimed and reimbursed prior to the individual leaving a nursing home and becoming a waiver participant.
- Case management furnished as an administrative expense may be eligible for FFP even if the person is not eventually served in the community (e.g., due to death, the individual's choice not to receive waiver services, loss of Medicaid eligibility, etc.). This is because the service is performed in support of the proper and efficient administration of the State plan. Further detail is available from the Olmstead III letter, referenced above.

### **Disadvantages**

- Only case management activities related to assisting an individual gain access to services covered by the Medicaid state plan or home and community based services waiver may be reimbursed.
- Services are reimbursed at the administrative rate (50% of case managers, or 75% for services provided by registered nurses) which may be lower than the FMAP for services depending on the provider of case management activities and the state's FMAP.

## **4. MFP Demonstration services**

The MFP Demonstration allows states to cover services under the demonstration that are not covered under the Medicaid state plan or a waiver. The RFP provides that:

States may choose to otherwise offer HCB demonstration services at the enhanced match rate by increasing the home and community-based services that it delivers during the demonstration period. Services that are offered under this category of "HCB demonstration services" are not required to be continued at the termination of the demonstration period.

If CMS policy limits or prohibits coverage of transition coordination, states may consider this option.

### **Advantages**

- States receive the enhanced match for case management services for qualified residents.

- States may limit the provider of case management services. Freedom of choice requirements for Medicaid waiver and state plan services do not apply.
- Activities performed prior to relocation may be claimed on the date the individual relocates from the institution.

### **Disadvantages**

- Case management costs for qualified residents who do not relocate might not be reimbursed depending on the scope of related changes.

## **5. Supplemental Demonstration services**

The MFP Demonstration allows states to cover supplemental services that are not typically covered under Medicaid state plan or waiver programs. The RFP does recognize that qualified residents face barriers to relocating to the community that can be addressed by the Demonstration. The RFP states that:

There may be barriers that are unaddressed through the State’s “qualified home and community-based program” or through enhanced HCB services that could be addressed by providing one-time services through the demonstration. The ability to provide these services may make it possible for States that are fairly advanced in their transition efforts but have specific barriers to overcome to continue to make progress. Any services provided, that are not qualified HCB long-term care services must be justified as essential to ensuring the advancement of Medicaid home and community-based care and overall rebalancing.

Supplemental services are reimbursed at the state’s regular FMAP rate and with demonstration funds and do not continue after the demonstration.

### **Advantages**

- Providers of case management services may be limited. Freedom of choice requirements for waiver and state plan services do not apply.
- Activities performed prior to relocation may be claimed on the date the individual relocates from the institution.

### **Disadvantages**

- Case management costs for qualified residents who do not relocate might not be reimbursed depending on the scope of related changes.
- Coverage as a supplemental service may be affected by the availability of other options for covering similar activities.

<b>Comparison of case management (transition coordination) options</b>					
<b>Function</b>	<b>Waiver service</b>	<b>TCM</b>	<b>Administrative activity</b>	<b>MFP Demonstration*</b>	
				<b>Demo service</b>	<b>Supplemental</b>
FFP	FMAP	FMAP	50%	Enhanced FMAP	FMAP
Limit providers	N	N	Y	Y	Y
Claim if no move	N	Y	Y	N	N
Scope	Medicaid & other services	Medicaid & other services	Medicaid services only	Medicaid & other services	Medicaid & other services

\* Coverage as a demonstration or supplemental service could depend on changes in CMS policy regarding the definition, scope and coverage case management activities.

This report was prepared by Robert Mollica, National Academy for State Health Policy, as part of the Rutgers Center for State Health Policy/NASHP Technical Assistance Exchange Collaborative funded by the Centers for Medicare and Medicaid Services.

*This document was developed under Grant Number P-91512/2 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government. Please include this disclaimer when copying or using all or any of this document in dissemination activities.*