Third Party Liability, Foster Care Services and the HCBS Waiver

Background

A principle tenet of the federal Medicaid program is that Medicaid is the payor of last resort. Medicaid regulations expressly prohibit the use of Medicaid funds when other resources such as private insurance or other federal programs are available and/or required to provide for the service. This prohibition appears in general Medicaid regulations and in the regulations governing the 1915(c) home and community-based services (HCBS) waivers as well.

Overarching Medicaid regulations under 42 CFR 433.135 through 433.153 lay out the conditions under which states must seek reimbursement from other parties or programs that are liable for payment, known as third party liability. Third party liability is defined as, “Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.”(42CFR433.136). While third party liability (TPL) is understood by most individuals as relating to private insurance, TPL also applies to any other federal program that is liable for payments for a service that otherwise is covered under the Medicaid program.1

Increased attention to TPL beyond capturing private insurance payments began in 1997 when the Centers for Medicaid and Medicare Services (CMS, the federal Medicaid agency) published a 77-page guide basically dedicated to informing schools what services can be claimed under Medicaid and what cannot. At least ten full pages of this guide were devoted to the interaction of Medicaid and TPL. CMS (then HCFA) clearly articulated and reiterated that Medicaid cannot pay when other resources are required to cover the service.2 (School-based claiming has been a controversial area, but recent guidance on the requirements around the concept of “free care” has made it clear that while Medicaid reimbursement can be claimed in school settings, TPL rules continues to apply.3)

Guide to Title IV-E Requirements: An Overview the Title IV-E Foster Care Maintenance Payments Program & Requirements for Specific Judicial Findings to Establish Eligibility”, Children’s Law Center University of South Carolina School of Law, 2012 http://childlaw.sc.edu/frmPublications/Title%20IV-E%20Guide%20Final.pdf

3 Information on free care is found at: http://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

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In 2001, CMS followed up the school claiming document with a State Medicaid Director letter regarding TPL and the payment of Medicaid targeted case management claims for children in foster care. Again, CMS clearly reiterated the principle of TPL, laying out the specific case management activities that could be claimed for under Medicaid for children in foster care, noting, “Since the Title IV-E program is not liable for the assessment, care planning, and monitoring of medical care needs, the cost for such activities could be billed to the State Medicaid program if the activities are furnished to a Medicaid eligible individual who is a member of a target group defined in the State plan. This also assumes that there is not another third party payer available to cover the costs of medical case management services provided to a Medicaid eligible individual.”

The 1915(c) HCBS Waiver and TPL

With the advent of the 1915(c) HCBS waivers in 1981, a new class of home and community-based services was now reimbursable under the Medicaid program. Some of the allowable HCBS waiver services include vocational services such as supported employment, training services for children and adults and residential placement for children. But there are other federal programs that have responsibility for vocational, educational and children’s residential services as well. The Individuals with Disabilities Education Act (IDEA) provides for a free, public education to children with disabilities up to age 22. IDEA, through the development of an Individual Education Plan (IEP) provides for a wide array of services and supports to children during the school day. The HCBS waiver application instructions expressly states, “Waiver funding may not be used to pay for special education and related services that are included in a child’s individualized Educational Plan (IEP) that must be furnished to a child under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). The funding of such services is the responsibility of state and local education agencies.”

This same type of prohibition exists for adults. Again the HCBS waiver application instructions indicate, “…services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973. When a state covers prevocational and/or supported employment services in a waiver, the waiver service definition of each service must specifically provide that the services do not include services that are available under the Rehabilitation Act (or, in the case of youth, under the provisions of the IDEA) as well as describe how the state will determine that such services are not available to the participant before authorizing their provision as a waiver service.”

And finally, with regard to children’s foster care services, CMS indicates HCBS waiver services to children in foster care can only supplement the basic services that must be covered under Title IV-E, which provides states with federal funding for children

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4 SMDL #1-013, January 19, 2001, Targeted Case Management and Foster Care

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residing in foster care settings. Title IV-E regulations read that foster care funds are intended to cover, “Foster care maintenance payments are payments made on behalf of a child eligible for title IV-E foster care to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel for a child's visitation with family, or other caretakers.”

CMS has issued guidance to states that provide waiver services to children residing in foster care. The waiver application instructions note that, “Waiver services may be furnished to children in foster care living arrangements but only to the extent that waiver services supplement maintenance and supervision services furnished in such living arrangements and waiver services are necessary to meet identified needs of children. Waiver funds are not available to pay for maintenance (including room and board) and supervision of children who are under the State’s custody, regardless of whether the child is eligible for funding under Title IV-E of the Act. The costs associated with maintenance and supervision of these children are considered a state obligation. The costs associated with the treatment of these children may be Medicaid reimbursable [under either the State plan or a HCBS waiver]. Depending on the nature of the treatment (i.e., habilitation), the costs of treatment may be eligible for FFP under a waiver. When waiver case management services are furnished to children in foster care who are eligible for Title IV-E funding, the state must ensure that the claim for FFP does not include costs that are properly charged as Title IV-E administrative expenses.”

State Experiences

Although many state waiver programs that include services to children with developmental disabilities cover residential services, very few of these waivers explicitly note they cover foster care services, although they may do so. Wisconsin is an exception to this and has explicitly listed foster care as a specific waiver service since it’s inception in 1983.

During their HCBS waiver renewal process in 2003, Wisconsin encountered a series of new questions regarding services to children in foster care settings. CMS expressed concerns that the waiver not pay for the costs of “regular” foster care (and child day care services as well). Since CMS had never previously questioned Wisconsin’s inclusion of foster care services under the HCBS waiver, a series of negotiations occurred that resulted in clarification that the HCBS waiver would only pay for, “supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs; or physical or personal care needs.” (A full copy of the approved language and policy included in Wisconsin’s waivers serving children is attached.)

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6 CMS also reminds states that HCBS waiver funds cannot be used for any room and board payments for anyone enrolled in the HCBS waiver except for respite services.
7 45 CFR 1355.20
Wisconsin also provided assurances that the waiver would not pay for either room and board or the basic costs of maintenance and supervision that are covered by Title IV-E.

Under Wisconsin’s waiver, the state can pay what is termed an “exceptional rate” for foster care services that reimburses the foster care providers at a rate above what Title IV-E payments provide. This additional reimbursement is only available to providers supporting children with certain emotional, behavioral or physical needs that are not typical to the general population of children in foster care, and thus in need of supports beyond what Title IV-E covers. The children in foster care are eligible for other waiver-funded services (of course with the prohibition of those covered under IDEA) such as environmental modifications, adaptive equipment and supplies or other services as determined through the individualized planning process. The policies developed around foster care all relate to payment for an exceptional level of care to foster care providers.

Wisconsin’s approved foster care services definition includes descriptions of the types of medical conditions, physical disabilities or behaviors that would permit a child in a foster care to qualify for waiver funded services. For example, behavioral and/or emotional problems that could qualify a child in foster care for waiver funded services include, “…severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent behavior…”. A myriad of other conditions such as the need for personal care beyond what is age-appropriate to intensive medical care such as tube-feedings can also qualify the child for additional funding in a foster care setting.

In order to evaluate and document the need for services beyond the basic Title IV-E funded services, Wisconsin developed a checklist titled,” Determination of Exceptional Care Needs for Children in Child Care and Foster Care Settings” to document the specific behaviors or conditions the child has that confirm the need for additional supports. (A copy of the checklist is attached to this document.) This documentation forms the basis for the determination that the provider is eligible for the exceptional payment above and beyond the Title-IV-E payment rates.

Utah

In June, 2004 CMS reviewed Utah’s HCBS waiver for children and adults with developmental disabilities. CMS conducts quality compliance reviews prior to the expiration date of each waiver to assure that the state is fully in compliance with regulations before submitting a waiver renewal. Utah, like Wisconsin, included residential habilitation for children and adults in their waivers since the inception of their waiver program, although Utah, unlike Wisconsin did not explicitly name foster care settings as a separate service in their waiver. Foster care services were included under the general description of residential habilitation.

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9 Found at: https://www.dhs.wisconsin.gov/sites/default/files/legacy/bdds/waivermanual/waiverch05_10.pdf#page=1

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As a result of the review, CMS informed Utah that they were to remove foster care services from their waiver and could no longer make HCBS waiver payments for children in foster care settings. CMS argued that payment for services for these children was the responsibility of the child welfare agency through funding under Title IV-E. Utah proposed a similar solution to Wisconsin’s, whereby Title IV-E funds would pay for basic maintenance and waiver funds would be available for exceptional needs. CMS then argued that other federal funds available to child welfare agencies under Title IV-B, an additional federal funding stream available to states for children in foster care, were to be used for these exceptional needs and again the HCBS waiver could not be used to support these children.

After considerable negotiations, CMS agreed to drop the issue of Title IV-B funds. This is a very limited pool of funding (capped at 1979 funding levels) that does not provide any where near the level of supports needed for children with significant developmental disabilities served in the foster care system. Much like Wisconsin (on whom Utah’s policies are modeled), an agreement was forged that the HCBS waiver could cover exceptional needs payments for children in foster care. (A copy of Utah’s approved residential habilitation service, including the policies on children in state custody are included are attached.)

Utah’s approved residential habilitation definition requires that, “Children in DCFS custody are eligible to receive this service only after the provision of this service has been prior-authorized by the minor’s support coordinator. Such prior-authorization will occur only after it has been determined that the minor has exceptional care needs that materially affect the intensity or skill level required of the service provider.” Basic maintenance costs must be covered by Title IV-E funds and the child must have exceptional care needs related to their behavior, medical or physical support. Also modeled on Wisconsin’s approved service, Utah provides a detailed list of conditions that meet this exceptional care requirement for payment of HCBS waiver funding to foster care providers.

As a condition of including the payment of waiver funds to children in foster care, Utah now must submit monthly billing reports to their CMS Regional Office documenting that Title IV-E payments have been made to the foster homes, assuring that TPL payments have been made for basic foster care services before accessing HCBS waiver funds.

**Conclusion**

As can be seen from the Wisconsin and Utah experiences, the issue of TPL in the HCBS waiver has become more salient in the last couple of years. States would be well-advised to review their waiver programs and policies regarding children in foster care in

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10 Title IV-B is divided into two parts, Subpart 1 funds may be used by states on almost any child welfare activity. Subpart 2 provides grants to states for child welfare services, such as family support services to enhance family stability or reunification activities, but is more restrictive in how the funds can be used.
anticipation of CMS reviews. Modeling foster care policies on Wisconsin and Utah’s approved waivers might be a good strategy to head off issues with TPL. And, based on Utah’s experience, the state may want to be prepared to provide documentation that the TPL payments under Title IV-E have been made.

ATTACHMENTS
DEFINITION

A Children’s Foster Home is a family oriented residence operated by a person licensed under §48.62, of the Wisconsin Statutes, and HFS 56 of the Administrative Code as a Foster Home, or residences operated by a provider licensed under HFS 38 of the Administrative Code as a Treatment Foster Home. Children’s Foster Homes and Treatment Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if all the foster children are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care; personal care; supervision; behavior and social supports, daily living skills training, and transportation.

SERVICE REQUIREMENTS/ LIMITATIONS/EXCLUSIONS

1. Excludes the cost of room and board provided by the Foster Care provider. Other disability or foster care-related funding sources generally cover these costs. Room and board costs are generally reimbursed by sources used to finance basic foster care.

2. Excludes the cost of basic support and supervision provided to children by foster care providers in these settings. These services are minimal and routine for children of the age of the child being served. Compensation for these services are not covered by the Medicaid Waivers and are generally covered by other funding sources associated with Foster Care.

3. Includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs; or physical or personal care needs. Examples to illustrate the range and scope of children’s exceptional emotional or behavioral care needs include severe hyperactivity to the point of destructiveness or sleeplessness; chronic withdrawal, depression or anxiety; self-injurious behavior, aggressive or violent behavior; history of running away for long periods of time; severe conduct or attachment disorders resulting in a significant level of acting out behavior; psychotic or delusional symptoms; eating disorders; repeated and uncontrollable social behavior resulting in property offenses, assault, arson, or sexual perpetrator behaviors such that comprehensive and intensive supervision and intervention are required throughout the day. Examples to illustrate the range and scope of children’s exceptional physical or personal care needs include: uncontrolled seizures; orthotic devices or appliances for drainage, a colostomy, or other similar device; requires direct assistance with personal cares, exhibits eating or feeding problems including tube or gavage feedings, requires specialized skin and positioning care to treat or prevent serious skin conditions such as pressure sores, requires follow-through on a therapy plan in excess of 2 hours per day, requires persistent monitoring of complex medical needs, or is non-ambulatory.
4. For children with physical or personal care needs, the types of activities that may be applied include direct personal care provision beyond those age activities expected for a child, skilled tasks such as tube or gavage feedings, catheterization, close supervision and monitoring of a child with complex medical needs, follow through on specific therapeutic interventions, and frequent positioning or specialized skin care. For children with emotional or behavioral care needs, the types of activities or interventions that may be applied include follow through on a comprehensive behavioral intervention plan, structuring the child’s environment to provide a significant level of predictability, organization and routine to minimize disruptive behaviors or address complex emotional needs, structuring the child’s environment to prevent aggression, elopement or other disruptive or violent behaviors.

5. Foster Care providers are required to have specialized training related to the child’s unique needs in order to effectively address the needs of each child served in a particular home and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the foster care providers must have training specific to the child’s needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

6. The support and supervision costs of serving the children with disabilities served may be established at a higher rate if the provider must serve fewer children because of the extra or exceptional care and supervision needs of the children placed in the home described in 3 above. To illustrate this, if a provider could otherwise serve four children and therefore be compensated at a higher amount, the amount they receive for the care they provide to the child with a disability may be adjusted to compensate for this difference.

7. Transportation services may be included under this service or separately billed under the service Specialized Transportation so long as there is no duplicate billing for any unit of service.

8. Excludes environmental modifications to the home, adaptive equipment or communication aids under this service. Any needed environmental modification, adaptive equipment or communication aid may be covered by the waiver but must be claimed under the services “Home Modifications,” “Communication Aids or Adaptive Equipment” respectively.

9. If Personal Care covered by the Medicaid State Plan is used by children served in the home, these services may not duplicate for services provided by the foster care providers.

10. Joint approval from DCFS and BDDS is required for the use of shift staff in a Treatment Foster Home prior to the placement of any waiver participant in the home.
11. All persons providing services and supports to any waiver participant shall be subject to a criminal and caregiver background check before they begin providing services. Both types of background checks must be repeated every four years. Persons who are listed on the caregiver register or who are found to have committed a crime substantially related to the provision of transportation services, care or supervision shall not be considered qualified for the provision of this service. General provider screening requirements for Medicaid Waivers apply to this service.

12. All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in Chapter 9.

STANDARDS

Foster homes must be licensed under HFS 56 FAMILY FOSTER CARE FOR CHILDREN or HFS 38 for Treatment Foster Homes.

DOCUMENTATION

1. All providers of foster care must have evidence of valid licensure.

2. The county agency must document that no waiver funds are being used to reimburse room and board costs.

3. There must be documentation of current criminal and caregiver background checks in the provider or licensing file.

4. There must be documentation that the services provided by the foster home sponsor do not duplicate personal care services if personal care services are also provided.

5. There must be documentation of the specific exceptional needs of the child and the individual psychiatric/behavioral care plan or individual medical care plan that the foster care provider will implement.

6. There must be documentation of the specific training the foster parent received related to the child’s needs and the psychiatric/behavioral treatment plan or individual medical care plan.
WISCONSIN
DETERMINATION OF EXCEPTIONAL CARE NEEDS
FOR CHILDREN IN CHILD CARE OR FOSTER CARE SETTINGS

Directions: Place a checkmark in the box for each of the needs that a child exhibits that may affect the intensity or skill level required of the provider of child care or foster care services. The child’s record must include documentation of the need, as well as a comprehensive medical or personal care, or psychiatric/emotional treatment plan as a result of these needs.

Emotional and Behavioral Needs:
The child must display at least one of the following characteristics and require a psychiatric or behavioral intervention plan as a result.

- The child has encopresis or enuresis during daytime hours several times per week.
- The child has severe hyperactivity to the point of frequent destructiveness or sleeplessness on a consistent basis.
- The child is chronically withdrawn, depressed or anxious.
- The child engages in bizarre or severely disturbed behavior.
- The child has a conduct or attachment disorder resulting in significant acting out behaviors.
- The child runs away for long periods of time returning only as a result of intervention of others.
- The child habitually creates a disturbance in the classroom or on the school bus such that there is daily parent to school contact required, the child is frequently truant, or unable to complete the school day as a result.
- The child exhibits high-risk behaviors including habitual alcohol or drug use, sexually promiscuous behavior, or sexual perpetrator behavior.
- The child engages in repeated and uncontrolled social behavior resulting in delinquency status such as property offenses, assault and arson.
- The child has aggressive behavior on a daily basis including biting, scratching or throwing objects.
- The child engages in self-injurious behavior such as head banging, eye poking, biting, picking, or cutting.
- The child has a severe eating disorder including anorexia nervosa, pica, or polydipsia.
- The child is severely withdrawn or has an extreme social phobia.
☐ The child exhibits psychotic or delusional behaviors.

☐ The child requires 24-hour awake supervision or care.

**Physical and Personal Care Needs:**

The child must display at least one of the following characteristics and require a medical or personal care intervention plan as a result.

☐ The child requires assistance with multiple personal care needs including dressing, bathing and toileting.

☐ The child requires catherization or ostomy care.

☐ The child must be fed, require tube or gavage feedings, or require direct supervision while eating to prevent complications such as choking, aspiration or excessive intake.

☐ The child requires frequent care to prevent or remedy serious skin conditions such as pressure sores or persistent wounds.

☐ The child requires suctioning.

☐ The child has a complex and unstable medical condition that requires constant and direct supervision.

☐ The child requires two or more hours of therapy follow-through per day.

☐ The child requires other complex medical, mediation or treatment follow through throughout the day.

☐ The child is not mobile and requires assistance with transfers and positioning throughout the day.

☐ The child requires 24-hour awake supervision or care.
Utah HCBS Waiver Services Definition

**Residential Habilitation**
Residential habilitation means individually tailored supports that assist with acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

Residential Habilitation Settings:
- Group Homes – Licensed facilities in which 4 or more individuals reside
- Supervised Private Residences – Individual supervised apartments or home settings in which 3 individuals or less reside
- Professional Parent Homes – Supervised Private Residences for 2 or less individuals under the age of 22.
- Host Homes – Supervised Private Residences for 2 or less individuals aged 22 or older.

Limitations: Payment is not made for the cost of room and board, the cost of building maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a residence required to assure the health and welfare of residents, or to meet the requirements of the applicable life safety code. Payment is not made, directly or indirectly, to members of the individual’s immediate family. Payment for this service is also unavailable to those who are simultaneously receiving any other services within this waiver that would be duplicative or overlapping in nature of the services contained within this service definition.

This service is available to minors in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services. For children in the custody of the Division of Child and Family Services, the costs of basic and routine support and supervision are not covered as waiver services. Compensation for this routine support and supervision are covered by other funding sources associated with the Division of Child and Family Services. Children in DCFS custody are eligible to receive this service only after the provision of this service has been prior-authorized by the minor’s support coordinator. Such prior-authorization will occur only after it has been determined that the minor has exceptional care needs that materially affect the intensity or skill level required of the service provider. Evidence that a minor in custody has such exceptional care needs include any one of the following: emotional or behavioral needs such as hyperactivity; chronic depression or withdrawal; bizarre or severely disturbed behavior; significant acting out behaviors; persistent attempts at elopement; habitual alcohol or drug use; sexually promiscuous behavior; sexual perpetration; persistent injurious or destructive behaviors; severe eating disorders including anorexia nervosa, pica or polydipsia; the presence of psychotic or delusional thinking and behaviors; or, the
minor otherwise demonstrates the need for 24-hour awake supervision or care in order to ensure the safety of the minor and those around him/her. Additionally, minors in custody of the State of Utah: Department of Human Services, Division of Child and Family Services may only receive this service if they demonstrate medical or personal care needs of an exceptional nature including any one of the following: requiring catheterization or ostomy care; requiring tube or gavage feeding or requires supervision during feeding to prevent complications such as choking, aspiration or excess intake; requires frequent care to prevent or remedy serious skin ailments such as pressure sores or persistent wounds; requires suctioning; requires assistance in transferring and positioning throughout the day; require two or more hours of therapy follow-through per day; requires assistance with multiple personal care needs including dressing, bathing and toileting; requires complex medical, medication or treatment follow-through throughout the day; or, the minor has a complex and unstable medical condition that requires constant and direct supervision.

This service is intended to accomplish a clearly defined set of outcomes associated with the child’s habilitation that is outlined in their individual support plan. Services provided under this service definition are only those that are over and above the basic routine supports provided for through the Division of Child and Family Services.
January 19, 2001

Dear State Child Welfare and State Medicaid Director:

The Department of Health and Human Services (HHS) is dedicated to providing support to children and other populations who receive case management services. We want to take this opportunity to clarify HHS policy on targeted case management services under the Medicaid program as it relates to an individual’s participation in other social, educational, or other programs.

When social programs or other programs are also the providers of Medicaid case management services, a number of complex issues may arise. This letter clarifies existing HHS policy regarding State plan case management and Title IV-E foster care programs. Specifically, this letter discusses: (1) the Medicaid definition of case management services, (2) whether services provided to individuals not eligible for Medicaid, or eligible but not part of the target population, can be covered, and (3) application of third party liability rules.

Please note that we anticipate issuing additional guidance for State plan case management as it relates to all programs through notice and comment rulemaking in the future.

I. Definition of Case Management Services

Sections 1905(a)(19) and 1915(g)(2) of the Social Security Act (the Act) define case management as services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services are referred to as targeted case management (TCM) services when the services are not furnished in accordance with Medicaid statewideness or comparability requirements. This flexibility enables States to target case management services to specific classes of individuals and/or to individuals who reside in specified areas.

Because the statute permits states flexibility to target Medicaid case management services based on any characteristic or combination of characteristics, States may use eligibility for, or participation in, a state social welfare program or other programs as the basis for defining the target population among Medicaid eligible individuals. Foster care programs employ their own case workers who, in addition to facilitating the delivery of foster care benefits and services, help individuals access and coordinate the delivery of other services. When foster case workers are also enrolled in Medicaid as providers of case management services, States must undertake a careful review to ensure the activities to be claimed under Medicaid meet the definition of case management and are not directly connected to the delivery of foster care benefits and services.
While HCFA has not further defined case management services in regulations, activities commonly understood to be allowable include: (1) assessment of the eligible individual to determine service needs, (2) development of a specific care plan, (3) referral and related activities to help the individual obtain needed services, and (4) monitoring and follow-up. When consistent with Medicaid requirements discussed below, Medicaid can be used to supplement these activities for Medicaid eligible individuals when they are embedded in another social or other program. We discuss below activities that are allowable case management as well as activities that would be unallowable as case management. In general, allowable activities are those that include assistance in accessing a medical or other service, but do not include the direct delivery of the underlying service.

**Assessment:** This component includes activities that focus on needs identification. Activities include assessment of an eligible individual to determine the need for any medical, educational, social, and other services. Specific assessment activities include: taking client history, identifying the needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, and educators, if necessary, to form a complete assessment of the Medicaid eligible individual.

**Care Planning:** This component builds on the information collected through the assessment phase and includes activities such as ensuring the active participation of the Medicaid-eligible individual and working with the individual and others to develop goals and identify a course of action to respond to the assessed needs of the Medicaid eligible individual. The goals and actions in the care plan should address medical, social, educational, and other services needed by the Medicaid eligible individual.

**Referral & Linkage:** This component includes activities that help link Medicaid eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered case management.

**Monitoring/Follow-up:** This component includes activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the Medicaid eligible individual. The activities and contacts may be with the Medicaid eligible individual, family members, providers, or other entities. These may be as frequent as necessary to help determine such things as (i) whether services are being furnished in accordance with a Medicaid eligible individual's care plan, (ii) the adequacy of the services in the care plan, and (iii) changes in the needs or status of the Medicaid eligible individual. This function includes making necessary adjustments in the care plan and service arrangements with providers.

**Unallowable services:** Medicaid case management services do not include payment for the provision of direct services (medical, educational, or social) to which the Medicaid eligible individual has been referred. For example, if a child has been referred to a state foster care program, any activities performed by the foster care case worker that relate directly to the provision of foster care services cannot be covered as case management. Since these activities are a component of the overall foster care service to which the child has been referred, the
activities do not qualify as case management. In the case of foster care programs, we view the following activities as part of the direct delivery of foster care services and therefore may not be billed to Medicaid as a case management activity. The following list is intended to be illustrative and not all inclusive: research gathering and completion of documentation required by the foster care program, 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. During the State plan approval process, HCFA will provide guidance to determine Medicaid billable activities.

II. Contacts with Non-eligible or Non-targeted Individuals

There is confusion involving contact with individuals who are not eligible for Medicaid or, in the case of targeted services, individuals who are Medicaid eligible but not part of the target population specified in the State plan. HCFA policy permits contacts with non-eligible or non-targeted individuals to be considered a Medicaid case management activity, and to be billed to Medicaid, when the purpose of the contact is directly related to the management of the eligible individual's care. It may be appropriate to have family members involved in all components related to the eligible individual's case management because they may be able to help identify needs and supports, assist the eligible individual to obtain services, provide case workers with useful feedback, and alert them to changes.

On the other hand, contacts with non-eligibles or non-targeted individuals that relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care cannot be billed to Medicaid. While the nature of the contacts may squarely fall into one of the components of case management (i.e., assessments, care planning, referral and follow-up), Medicaid cannot be used to pay for them due to the fact that the individual is not Medicaid eligible or is eligible but does not meet the targeting criteria set by a State in its State plan amendment.

III. Third Party Liability

In accordance with Medicaid third party liability policy, Medicaid would only be liable for the cost of these services if they fall within the definition of case management and there are no other third parties liable to pay.

The Administration for Children and Families has clarified that the Title IV-E program does not authorize reimbursement for the assessment, care planning, and monitoring of medical care and services. Since the Title IV-E program is not liable for the assessment, care planning, and monitoring of medical care needs, the cost for such activities could be billed to the State Medicaid program if the activities are furnished to a Medicaid eligible individual who is a member of a target group defined in the State plan. This also assumes that there is not another third party payer available to cover the costs of medical case management services provided to a Medicaid eligible individual.
In contrast, referrals to medical care providers are Title IV-E reimbursable. This means that referrals are not billable to Medicaid. Because Title IV-E is liable for covering case management for a range of other services (including referrals to medical care), States which offer Medicaid case management services to foster care populations must properly allocate case management costs between the two programs in accordance with OMB Circular A-87 under an approved cost allocation program.

If you have any questions, please contact Mary Jean Duckett, Director, Division of Benefits, Coverage and Payment, Disabled and Elderly Health Programs Group at 410-786-3294.

Sincerely,

/s/
Olivia A. Golden
Assistant Secretary for Children and Families

/s/
Timothy M. Westmoreland
Director
Center for Medicaid and State Operations
Health Care Financing Administration

cc:
ACF Regional Administrators HCFA
Regional Administrators
HCFA Associate Regional Administrators for Medicaid and State Operations
Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association