



Medicaid and Case Management for People with Developmental Disabilities: Structure, Practice, and Issues

Third Edition
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NASDDDS

**Medicaid and Case Management
for People with Developmental Disabilities:
Structure, Practice, and Issues**

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EXECUTIVE SUMMARY

The National Association of State Directors of Developmental Disabilities Services (NASDDDS) promotes and assists state agencies in developing effective, efficient service delivery systems that furnish high-quality supports to people with intellectual and developmental disabilities and their families. NASDDDS strives to provide member state agencies with timely analyses of federal statutory and regulatory policies that affect people with disabilities; disseminate cutting edge information on state-of-the-art programs and service delivery practices; provide technical assistance and support to member states; and offer a forum for the development of state and national policy initiatives.

In the last 20 years, state spending in Medicaid funds for home and community-based services (HCBS) for people with intellectual and developmental disabilities (I/DD) has increased by 825%. Informed by the recently released HCBS Waiver Technical Guide, Version 3.6, and requirements for person-centered planning and eliminating conflict of interest in case management, services the third edition of *Medicaid and Case Management for People with Developmental Disabilities: Structure, Practice, and Issues* delivers detailed updates, explanations, and examinations of federal statutory and regulatory policies governing case management practices and funding. NASDDDS complements these analyses and explores current practice with 2018 survey data from 45 states, providing in-depth information on state case management systems.

This report breaks down the role of the case manager in both regulation and practice, delineating the boundaries between Medicaid requirements and state flexibility in meeting these requirements. The report covers the many case management financing authorities and strategies particularly within Medicaid, along with Medicaid requirements for person-centered planning and case management conflict of interest elimination and/or mitigation.

In Section 1, learn about the growing significance of case management in the provision of services to individuals with I/DD and their families.

Section 2 offers detailed explanations of Medicaid requirements for case management services and professionals. Survey data offers insights into how each state defines case manager requirements, such as experience, training, and documentation practices. State data also informs case management caseloads and rate methodologies. This section concludes with the Authorities at a Glance table (pages 19-21) which details the regulations, persons served, Federal Financial Participation rate, covered activities, limitations, and provider types eligible across different Medicaid funding authorities.

Section 3 details how states may utilize multiple case management funding vehicles to find the best fit in terms of the population being served, scope of services, and preferred provider types. Following a review of statutory definitions of case management functions and opportunities for state latitude, this section offers key considerations in the selection of a Medicaid funding authority, specifically the

1915(c) HCBS waiver, 1915(g) Targeted Case Management, Administrative Claiming, and Managed Care.

Section 4 provides on-the-ground accounts of case management funding strategies through analysis of the state survey data. This section highlights state definitions of case management, the number of individuals served by each funding type, use of non-Medicaid funding, and caseload ratios.

Section 5 focuses on the HCBS Conflict of Interest regulations. Visit the Conflict of Interest Crosswalk (Figure 14, pages 43-4) for details on the regulation, applicable rules, technical guidance, eligible activities, eligible providers and more for TCM, 1915(c), 1915(i), and 1115 research and demonstration waiver. This portion concludes with examples of how states have addressed conflicts of interest in their state systems.

The final section delves deeply into the role and functions of the case manager, particularly highlighting the significance of person-centered planning.

Medicaid and Case Management for People with Developmental Disabilities: Structure, Practice, and Issues sheds light on key issues in case management service provision. This report breaks down the most relevant statutory and regulatory guidelines and highlights state responses, strategies, and discoveries, culminating in a timely and practical guide for ensuring regulatory compliance, offering examples of effective practices in providing high quality, person-centered support to individuals with I/DD and their families.

Visit [NASDDDS.org/publications](https://www.nasddds.org/publications) or [NASDDDS.org/publications/newsletters](https://www.nasddds.org/publications/newsletters) to access our other publications or subscribe to our newsletters.

SECTION 1: INTRODUCTION

Case management is a pivotal support for individuals and families navigating the services system. Case managers are typically the central professional individual with whom people with disabilities and their families develop relationships. They assist the individual and family in understanding the services system, making informed choices about services and supports, and engaging in high quality, person-centered planning. Case managers also have crucial roles in assuring individuals' health and well-being. Through their engagement with individuals and families case managers set expectations about the services system, its opportunities and limitations. Case managers also act as an agent of the state. They are often the "front line" of state quality management efforts and have responsibilities for assuring and overseeing provider, and sometimes individual and family, adherence to state and federal regulations.

Over the past three decades, our services systems have shifted. Medicaid is now the single largest source of funding for home and community-based services (HCBS), including case management.

To understand our systems today, during the period of April-June 2018, the National Association of State Directors of Developmental Disabilities Services (NASDDDS) conducted an online survey of member state developmental disabilities agencies about their case management systems. Of the 50 states and the District of

Columbia, 45 states completed the survey. The survey consisted of 51 questions covering state case management practices including financing authorities, system structure, payment rates, qualifications, caseload ratios, quality management, and the impact of the CMS 2014 conflict of interest requirements. Results from the survey inform this report.

Our systems have grown. In 1995 states spent about \$4 billion on HCBS for people with intellectual and developmental disabilities (I/DD). As of 2016, states were spending \$37 billion in Medicaid funds for HCBS for individuals with I/DD.¹ Case management systems have also grown to support the individuals enrolled in HCBS programs. The 45 states reported in the survey that they serve 967,637 individuals using Medicaid case management financing options.

Case management plays a central role in assuring services quality and outcomes for people enrolled in Medicaid-financed HCBS. Recognizing this, the Centers for Medicare & Medicaid Services (CMS) established new regulations and requirements for the provision of case management services.² This publication provides an in depth examination of these federal regulations including the new requirements for person-centered planning and conflict of interest disclosure. We make every attempt to use published regulations and CMS guidance as the backbone of this report. That said, some observations in this report may be subject to more than one interpretation. ***We always encourage states to work closely with their state Medicaid agency and CMS***

¹ Eiken, S, Sredl, K, Burwell, B, Amos, A, Medicaid Expenditures for Long-Term Services and Supports in FY 2016, May 2018 IAP, IBM Watson Health, p. 15.

² CMS is the federal agency that has regulatory authority over the Medicaid and Medicare programs.

regional and central office personnel on any regulatory and policy interpretations.

Medicaid

Authorized by Title XIX of the Social Security Act, Medicaid became law in 1965. All states, the District of Columbia, and the U.S. territories participate in Medicaid to provide health coverage and an array of long-term supports to children, low-income adults, and people with disabilities. The federal government establishes core requirements that all states must follow, but states have significant latitude and flexibility in establishing eligibility and optional services and supports which results in distinct Medicaid programs across the country.

Explanation of the Terms "Case Management" and "Case Manager"

We use the term "case manager" as a general "marker" of a wide range of activities. Case management activities typically have two key features: (a) providing an "interface" or connection between individuals with disabilities and the system of publicly funded and generic services and supports and (b) assuring that

these services meet reasonable standards of quality and lead to important outcomes for individuals. These two central features typically include a variety of activities such as intake, service authorization, individual plan development, ongoing monitoring, formal review of supports and services to assure quality and outcomes, and planning for and implementing changes in supports and services. Many terms are in use to describe these activities, such as support coordination, resource coordination, service coordination, and, in managed care arrangements, care coordination. Some of the activities within the scope of what we are terming case management may be performed by individuals in other roles. For example, a state may have trained person-centered planning facilitators who develop the person-centered plan, or individuals who do specific quality management activities.

As with our past publications on this topic, our use of the term "case management" in no way implies that people are "cases" who require external or professional "management." It merely represents a term of convenience and familiarity in wide usage among states and within CMS rules, regulations, and guidance.

Other common acronyms and terms we use³

CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COI	Conflict of Interest
I/DD	Intellectual and Developmental Disabilities
HCBS	Home and Community-Based Services
PCP	Person-Centered Planning
State Plan	The Medicaid state plan document is the agreement between the state and the federal government about how the state administers its Medicaid programs. The state plan lays out what required (mandatory) and additional (optional) eligibility groups and services the state will cover. The state plan also includes assurances that the state will adhere to all federal rules in order to claim federal funds for state plan covered services, programs and activities.
SMA	State Medicaid Agency, the organization statutorily responsible for administering the state's Medicaid program
TCM	Targeted Case Management
Technical Guide	The Application for a §1915(c) Home and Community-Based Waiver, Version 3.6, Instructions, Technical Guide and Review Criteria, CMS, January 2019

Medicaid Authorities that Fund Case Management Activities

The Medicaid program provides a number of options for funding case management activities. While there are many similarities funding authorities there are also significant differences. Parsing these nuances among funding authorities is crucial to decide which authority is the "best fit" for the goals and outcomes the state and stakeholders have in mind. In addition, states will want to match the funding authority to the state's case management structure and the scope of responsibilities for case managers.

The *Authorities "At-a-Glance"* Table, beginning on page 19, identifies key features of each of the funding authorities that finance case management. In the next section we provide definitions of case management provided by CMS either in guidance or regulation. In addition, we offer a list of key features about each option that can inform states' decisions as to which funding authority best matches state and stakeholders' goals.

1915(i) State Plan HCBS and 1915(k) Community First Choice (CFC)

We will generally focus on case management provided under the HCBS waiver, targeted

³ See full list of acronyms in Appendix A.

case management (TCM) under the state plan, and the use of administrative claiming to cover certain case management activities. Case management is also available under the 1915(i) state plan HCBS. We do not go into particular detail with regard to this authority as CMS has indicated that 1915(i) case management is subject to the same criteria and rules as the HCBS waiver, with one exception described below in Section 5. Per CMS's suggestion, states providing case management under 1915(i) should refer to the 1915(c) HCBS waiver guidance (or the targeted case management or administrative claiming depending on which authority is used) for individuals served under the 1915(i). Since CFC does not cover comprehensive case management other than supports for self-direction, we do not detail this option other than its conflict of interest requirements. Extensive information about CFC is available at www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html.

SECTION 2: CASE MANAGEMENT REGULATIONS, DEFINITIONS, AND KEY FEATURES

Overarching Medicaid Requirements

Regardless of which authority is used for service provision, case management (as with all Medicaid services) is subject to "overarching" Medicaid requirements.

Non-Duplication

Federal policy requires that services offered under various Medicaid coverages are non-duplicative. In general, this means that a single individual cannot receive the same type of Medicaid-funded service under two distinct coverages at the same time. As an example, a person with case management funded under an HCBS waiver program may not receive targeted case management services under the state plan concurrently. CMS's instructions regarding TCM state that "Payments for case management services under 1915(g) of the Act may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose" (State Medicaid Manual (SMM), 4302.2.F).⁴ However, an individual may be eligible for both TCM and waiver case management if the state carefully delineates any differences to assure that there is no duplication of the service to that individual. This prohibition on duplicating service applies to all services offered through

Medicaid, whether through the state plan (including 1915(i)), a HCBS waiver or other type of waiver such as a managed care or 1115 research and demonstration waiver. For example if an individual is enrolled in both a 1915(c) HCBS waiver and a 1915(i) state plan HCBS option, the state will need to assure that similar services — such as case management, if covered under both programs — are non-duplicative.

CMS does permit "overlap" between two services, as long as both services are not be billed simultaneously for the same recipient for the same activity. CMS does permit states to cover a service (for adults) both under the state plan and under the HCBS waiver as long as the state plan services are accessed first and the benefit "exhausted" before using the waiver service.⁵ States have used this option to extend additional therapies or nursing services to adults in need of service beyond the levels allowable under the state plan.

Children in foster care may receive two types of case management. The child may have a foster care case manager (who may be federally funded under Title IV-E) and receive TCM or waiver case management for the oversight of services not related to foster care. The HCBS waiver Technical Guide (hereafter known as the Technical Guide) addresses this situation: "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

⁴ The State Medicaid Manual is only available in paper format at this time, although some SPAs, which form a part of the SMM, can be found online at www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html. Each State Medicaid Agency has a copy of this manual.

⁵ Services to children that can be covered under the state plan must be under the provisions of EPSDT, thus extended state plan services are not available to children. See www.medicaid.gov/medicaid/benefits/epsdt/index.html and www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.

include costs that are properly charged as Title IV-E administrative expenses."⁶

waiver which are not available under the state plan).

42 CFR §441.18 Case Management [abridged]

(a) If a state plan provides for case management services (including TCM services), as defined in §440.169 of this chapter, the state must meet the following requirements:

(2) Not use case management (including TCM) services to restrict an individual's access to other services under the plan.

(3) Not compel an individual to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services.

Coverage of services is not considered distinct when the sole difference lies in the amount of or the method of payment for the service.

When proposing to cover a service that potentially overlaps the state plan coverage of a similar service, the state should include information in the service definition that clearly delineates how the two coverages differ.⁷

A good example of a state's approach to non-duplication is **California's** targeted case management state plan amendment (SPA) for individuals at risk of institutionalization. Their approved SPA clearly delineates the group served under TCM and other authorities:

According to the Technical Guide,

When a service coverage is proposed that appears to duplicate a state plan coverage, CMS will probe more deeply to determine whether the proposed waiver coverage is sufficiently distinct from the state plan coverage to warrant approval. The coverage generally is considered distinct when:

(a) the scope of the waiver coverage is materially different from the state plan service,

(b) the providers of the waiver service are different from the providers of the state plan service; and/or, (c) the method of service delivery is different (this difference may entail the availability of participant direction options under the

For those individuals in this target group, who may receive case management services under a waiver program, case management services shall not be duplicated, in accordance with Section 1915(g) of the Social Security Act. This target group excludes persons enrolled in a Home and Community-Based Services waiver program from receipt of TCM services.⁸

Freedom of Choice

Freedom of choice among qualified providers is a basic tenet of Medicaid coverage.

Freedom of choice refers to both the right of providers to choose whether to participate in the Medicaid program, and, more critically, the right of individuals enrolled in the Medicaid program to choose providers from among those participating in the state's Title XIX

⁶ Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, Includes Changes Implemented through January 2019] Instructions, Technical Guide and Review Criteria, CMS, January 2019, p. 121.

⁷ Ibid., p. 119.

⁸ A copy of this approved SPA can be found at

www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM%20SPAs/SPA%202017/CA_SPA_17-036.pdf.

program. Section 1902(a)(23) of the Social Security Act states, "Recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them."⁹ Later in the same section, the implementing regulations make it clear that, with certain specified exceptions, an eligible individual may obtain services from any institution, agency, organization or person that is, "qualified to furnish the services; and [w]illing to furnish them to that particular recipient."¹⁰

The Technical Guide also provides guidance on freedom of choice, indicating that waiver participants must be afforded choice of providers when case management is an HCBS waiver service. Although a part of overarching Medicaid regulation, freedom of choice plays out differently within the various Medicaid authorities used to finance case management. These variations on the applicability of freedom of choice regulations are included in the detailed descriptions of each of the authorities below.

Provider Qualifications

Medicaid regulations require that as a condition of reimbursement, services must be rendered to a Medicaid-eligible individual by a qualified provider who has a provider agreement with the Medicaid agency. As described in subsequent sections, CMS affords states considerable flexibility in defining the scope of responsibility and definition of case management. This same flexibility is allowable

in defining provider qualifications. While some services (typically under the state plan) have statutory requirements about certain provider qualifications, the Medicaid case management authorities do not specify provider qualifications.¹¹

Although Medicaid regulations do not set specific qualifications for case management or other waiver (or 1915(i) or CFC) providers, the regulations do express the expectation that providers are qualified for the service they deliver. For example, with regard to the HCBS waiver, regulations at "42 CFR §441.302(a) require that: (a) there are adequate standards for all types of providers that provide services under the waiver and (b) that the standards must be met when services are furnished."¹² The Technical Guide very explicitly defines that states have latitude in determining provider qualifications:

CMS has not promulgated minimum provider qualifications for waiver services. States have latitude in establishing appropriate qualifications. Like other Medicaid services, waiver services are subject to any relevant requirements contained in state law. However, provider qualifications must be reasonable and appropriate in light of the nature of the service. They must reflect sufficient training, experience, and education to ensure that individuals will receive services from qualified persons in a safe and effective manner.¹³

⁹ 42 CFR §431.52(a)(1).

¹⁰ 42 CFR §431.51(b)(1).

¹¹ In contrast to case management services, ICF/IID conditions of participation specify both the type of personnel and the qualifications of certain personnel in regulations. As an example, 42 CFR Part §483.430 requires the ICF/IID to have staff who are a "qualified intellectual disabilities professional" (among a host of others) whose qualifications are also described in statute.

¹² Technical Guide, p. 123.

¹³ Ibid., p. 129.

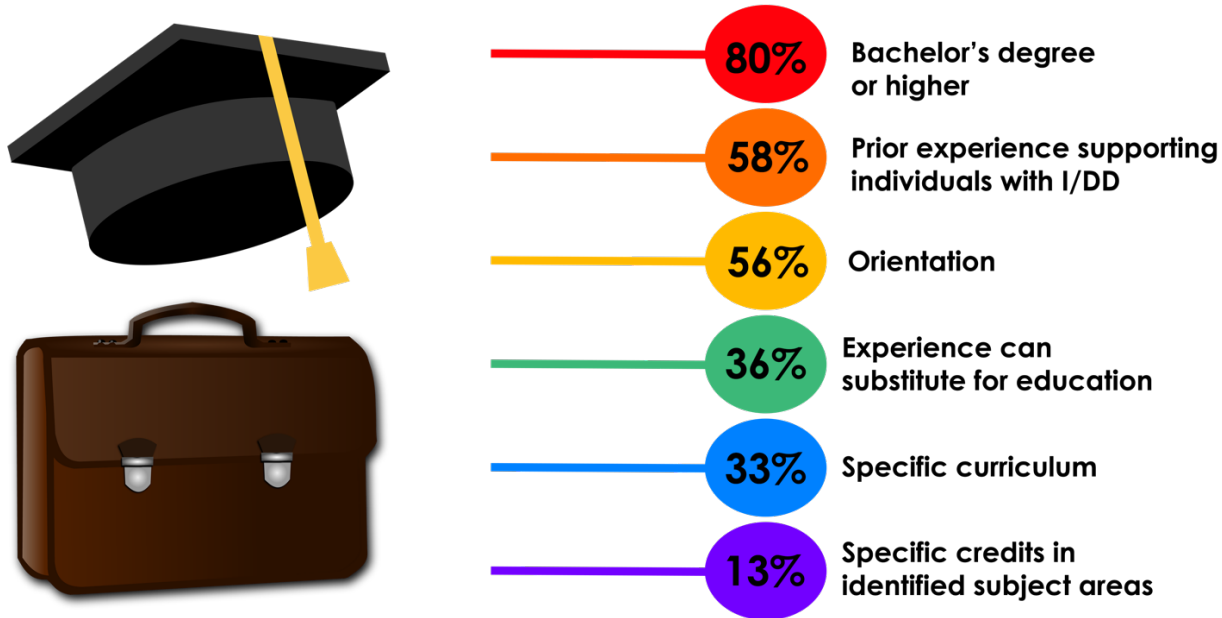
The Technical Guide specifies three ways that states can qualify providers:

1. Issue a license under their state laws;
2. Award a certificate issued by state agency or some type of accreditation body, for

example by quality review body for a national accreditation organization; or,

3. Other standards promulgated specific to the state.¹⁴

Figure 1. State Provider Qualification Requirements (N=45)



NASDDDS survey results indicate that, of 45 states responding, 36 states (80%) require a bachelor's degree or higher for case managers. Twenty-six states note experience in working with individuals with I/DD is a requirement to be a qualified provider. One state that permits individual case management practitioners sets a higher bar for these practitioners than agency-based case managers. Case managers who work for a case management agency must have a degree and two years of experience. Solo practitioners must have a bachelor's degree and three years of paid, supervised experience in developmental disabilities, special education, mental health, counseling, guidance, social work, or health and rehabilitative services. The qualifications

also permit that a master's degree in a related field can substitute for one year of the required experience.

Training Requirements

As with provider qualifications, CMS does not specify the training states must provide to case managers. States, in addition to the initial educational and experiential requirements, require additional on-going training once providers are enrolled. According to the NASDDDS survey, 29 states (63%) require case managers to attend orientation training. Nineteen states (41.3%) have a required specific curriculum for training all case managers. With increased emphasis on employment for individuals with disabilities and

¹⁴ Ibid., p. 128-9.

the HCBS rules on person-centered planning, states have added topic specific training requirements to case management qualifications. Of our 45 respondents, 44 (98%) require training in person-centered planning. In terms of training specific to promoting employment, 17 states (23%) indicated they provide training to case managers focused on employment outcomes. In addition to employment specific training, 14 states reported that case managers track employment outcomes using templates.

Figure 2. Case Management Training Requirements



The **Missouri Division of Developmental Disabilities** offers an eight-module training for supports coordinators that includes Missouri DD employment expectations and explains the Daily Life and Employment Exploratory Questions Tool. Support coordinators use this tool to generate employment discussions

during the planning process and individual support plan (ISP) development. The training module can be found at dmh.mo.gov/videos/ISP-Guide-Training/Module3.swf (requires Adobe Flash Player).

The **Pennsylvania Office of Developmental Programs** requires new supports coordinators (SCs) to receive orientation, which includes education about Employment First. The Employment First Tip Sheet and Pathway to Employment Guidance for Conversations documents help SCs introduce conversations about employment and identify a person's pathway to employment. SC orientation can be accessed at www.myodp.org/course/view.php?id=1092.

Documentation

Case management documentation:

- Assists individuals to establish eligibility
- Gathers information about the individual important to planning
- Documents the individual's preferences and desired outcomes
- Provides evidence of monitoring and oversight
- Tracks individual outcomes against the person-centered plan
- Establishes the basis for billing for services

Individual Records

Much case management documentation centers on the individual and provides an ongoing record of how the individual is supported to reach their outcomes. Individual records are essential to the continuity of supports especially when there is turnover in case managers. Sound, up-to-date information regarding the individual is essential to their well-being.

All Medicaid funded programs require the documentation of services delivered. In addition, all providers are required to have a provider agreement with the state Medicaid agency that typically describes the minimum documentation requirements.¹⁵ Section 1902(a)(27)(A) (27) of the Social Security Capital Act describes the requirement that all providers agree,

- A. to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the state plan, and
- B. to furnish the state agency or the secretary with such information, regarding any payments claimed by such person or institution for providing services under the state plan, as the state agency or the secretary may from time to time request.

While a comprehensive look at documentation requirements and processes is outside the scope of this report, examination of the regulations regarding targeted case management and the Technical Guide shed light on CMS's documentation expectations.

The regulations on TCM record keeping (42 CFR §441.18(a)(7)) specify that the minimum documentation case records need to include:

- i. The name of the individual.
- ii. The dates of the case management services.
- iii. The name of the provider agency (if relevant) and the person providing the case management service.

- iv. The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.
- v. Whether the individual has declined services in the care plan.
- vi. The need for, and occurrences of, coordination with other case managers.
- vii. A timeline for obtaining needed services.
- viii. A timeline for reevaluation of the plan.

CMS is not prescriptive as to how states fulfill these requirements. States can go beyond what is listed here in order to fully support the development and implementation of a person-centered plan.¹⁶

Billing Validation

Documentation also establishes and verifies the basis for claims to Medicaid. Under the HCBS waiver program a key case management function is to assure the array of services listed in the individual service plan (called the Plan of Care in the Technical Guide) that has been approved matches the billing for all service provision including case management.

In terms of documentation for the purposes of validating billing, the above is the minimum required to support a Medicaid claim.

- The individual was eligible for Medicaid waiver payment on the date of service;
- The service was included in the participant's approved service plan; and
- The services were provided.¹⁷

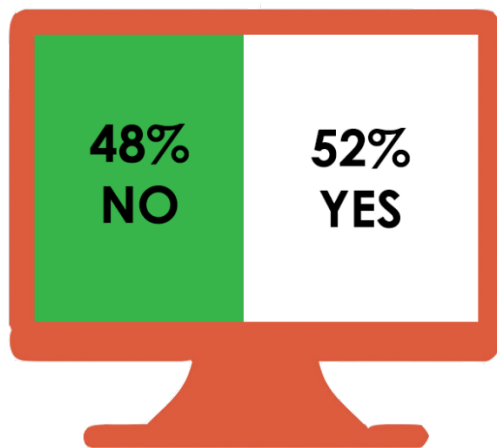
¹⁵ The provider agreement may be executed by the state Medicaid agency or by designee. For information on provider agreements see 42 CFR §431.107 - Required provider agreement. See Technical Guide, p.123.

¹⁶ For more information on documentation requirements see the State Medicaid Manual: 4302.2 of the CMS State Medicaid Manual: nashp.org/wp-content/uploads/sites/default/files/abcd/abcd.ut.tcm.prov.med.manual.pdf or www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html. Download zip file and go to sm_4_4270_to_4390.1.doc.

¹⁷ Technical Guide, p. 257.

Comprehensive documentation is essential to assuring robust person-centered planning and the continuity of information needed to support the individual. And the documentation must support the Medicaid claim for reimbursement, again demonstrating that the person was Medicaid eligible, the services were authorized as part of the person-centered plan and the services were actually delivered to the individual. In addition to the Technical Guide, CMS guidance can be found at www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/documentation-matters.html.

Figure 3. Use of Electronic Records



The 2018 NASDDDS survey asked states if they use electronic records for documenting case management activities. Of the 42 states responding to this question, 20 states or 48% use electronic records while 22 states or 52% do not. Several states reported the use of "commercial off-the-shelf (COTS)" case management record-keeping products that are variably customized for their state needs. Other states indicated they have developed their own

"in-house" systems while some have commissioned custom-made systems from external vendors. Based on some of the narrative replies we received, there is significant variability in whether or not the state operates the same electronic record system on a statewide basis. Some states permit providers to develop and use their own systems (often a COTS application); while at least 17 of the 24 states using electronic record-keeping for case management have statewide systems used by all providers. States indicated that many of their systems are comprehensive, covering all aspects of case management activities from intake information to person-centered planning and monitoring.¹⁸

For example, **Wyoming** reported they use a custom-built system called the Electronic Medicaid Waiver System. All of the state's HCBS waiver programs electronically house participant demographic information, eligibility information, critical incidents, and plans of care, participant goals, medication history, and other relevant medical information. Independent case managers, case management agencies, and state staff all use the system for day-to-day work processes.

Florida already has an electronic system for their individual budgeting and cost planning,¹⁹ and is in the process of implementing an electronic client central record system called iConnect.²⁰

The **District of Columbia Developmental Disabilities Administration (DDA)** uses a case management system developed by their own internal information technology department. Internal IT continues to modify the

¹⁸ www.in.gov/fssa/files/PCISP%20Guidelines%20v3.6%20FINAL.pdf, Appendix A, p. 21-22.

¹⁹ apd.myflorida.com/ibudget/users.htm.

²⁰ apdcares.org/waiver/iconnect/.

system based upon DDA needs. Additionally, the District of Columbia is working with both their Medicaid and Aging Agencies to build a joint system for intake.

Indiana's Bureau of Developmental Disabilities Services (BDDS) instituted a statewide electronic record portal used by case managers for person-centered planning, demographics, reports, and case noting. BDDS characterizes the system as a part of their efforts to focus on a strength-based, person-centered approach to supports and services through changes to information technology systems. The intent is to better reflect the needs of the individuals supported. Indiana's newly developed Person-Centered Individualized Support Plan (PCISP) is fully supported by the electronic record system. The PCISP process incorporates current best practices including using the Lifespan approach to working with families.²¹ The BDDS *Person-Centered Individualized Support Plan (PCISP) Guide* published in April 2018, provides a more detailed explanation of the elements captured by the electronic record system.²²

Financing Case Management Functions within Medicaid

States may elect to finance their case management functions through a number of different vehicles within Medicaid. States may cover case management as an allowable administrative activity, as a service under the state plan, as a service within the 1915(c) HCBS waiver program, or through other Medicaid authorities, such as those used to implement managed care or to develop a

health home benefit. Each of these options has different requirements and features, making their election dependent on many state-specific design factors.

Administrative Claiming for Case Management

Title XIX of the Social Security Act (the Act) authorizes federal grants to states for a proportion of expenditures for medical assistance under an approved Medicaid state plan, and for expenditures necessary for administration of the state plan. This joint federal-state financing of expenditures described in section 1903(a) of the Act, sets forth the rates of federal financing for different types of expenditures. Administrative activities are those functions that are "found necessary by the Secretary for the proper and efficient administration of the state plan." Case management is eligible for administrative claiming to the extent that the functions performed comport with the following requirements:

- Costs must be "proper and efficient" for the state's administration of its Medicaid state plan (Section 1903(a)(7) of the Act).
- Costs related to multiple programs must be allocated in accordance with the benefits received by each participating program (OMB Circular A-87, as revised and now located at 2 CFR 200). States can accomplish this by developing a method to assign costs based on the relative benefit to the Medicaid program and the other government or non-government programs, meaning that the state must be able to document the proportion of the activity that can be tied to Medicaid-related functions.

²¹ www.nasddd.org/projects/community-of-practice-supporting-families-throughout-the-lifespan.

²² www.in.gov/fssa/files/PCISP%20Guidelines%20v3.6%20FINAL.pdf.

- Costs must be supported by an allocation methodology that appears in the state's approved Public Assistance Cost Allocation Plan (42 CFR §433.34).
- Costs must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a provider facility.
- Costs must not duplicate payment for activities that are already being offered or should be provided by other entities, or paid through other programs.
- Costs may not supplant funding obligations from other federal sources.
- Costs must be supported by adequate source documentation.

In order to submit claims to CMS for administrative case management functions, these activities must be included in the state's approved cost allocation plan. The state Medicaid agency should consult with CMS Regional Office Financial Management analysts in developing administrative claiming methodologies to confirm which activities are allowable and whether the allocation method is reasonable. Generally, states will want CMS to specifically approve the methodologies. This step is important to avoid disputes and/or disallowances later.

The state's administrative claiming methodology must adhere to the cost determination and allocation guidelines for state, local, and tribal governments expressed in 45 CFR Part 75 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards. States have significant flexibility to determine the method of payment to the entities providing case management through contractual agreements

or other arrangements under administrative claiming authority.

Service Rates in Medicaid

States may also elect to cover case management as a service within Medicaid. According to the NASDDDS case management survey, of the 45 states responding, 23 states cover case management as a state plan service and 19 states cover it as a service within the waiver. When electing to cover case management as a service, states have latitude to determine the amount, duration and scope for service, within federal parameters. In addition, per Section 1902(a)(30)(A) of the Social Security Act, states must,

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section [1903\(i\)\(4\)](#)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Common Rate Setting Methods and Notable Approaches

When states offer case management as a service, CMS requires the state develop a rate methodology to determine the amount to be paid to providers. In a fee-for-service (FFS) environment, states must identify the unit of measure for the service and the strategy to determine the rate. CMS describes three

methodologies for payment rates in the Technical Guide:

- Prospective
- Retrospective (cost settlement of interim rates)
- Fee Schedule

For each service, including case management, the state must describe:

- Methods that are employed to establish provider payment rates
- Entities that are responsible for rate determinations
- Opportunity for public comments on rate setting

CMS also provides information in a PowerPoint presentation entitled *Rate Methodology in a FFS HCBS Structure*, which can be found at CMS.gov.²³ Additional CMS guidance on rate setting can be found on www.Medicaid.gov under *Home & Community-Based Services Training Series*.²⁴

Increasingly, in a fee-for-service delivery system, fee schedules are the most typical method of rate development. A fee schedule rate methodology results in a consistent rate paid to all providers for the same service. Fee schedule rate models may include a variety of factors, including:

- Wages
- Productivity Assumptions
- Benefits Factor
- Administrative Overhead
- Program Support Costs
- Paid Time Off and Training Time
- Staffing Ratios/caseload (including supervisory assumptions)

For any service, but especially for case management, the relationship between the scope of service as defined and the commensurate rate for the service is critically important. The service definition or scope of the service provides the foundation for permissible activities that are billable. For case management, in particular, the types of activities that a case manager may undertake on behalf of an individual should be articulated within the service definitions to be construed as billable. The service rate also includes productivity assumptions, crucial to calculate the amount of "billable" time spent during an 8-hour day or 40-hour week in which service was directly provided. Therefore the definition of what constitutes the direct service is pivotal.

Figure 4. Case Management: Units of Service

TIME	TCM	HCBS Waiver	1115	Admin	(b)/(c)
5 minute	2	0	0	0	0
15 minute	10	3	0	0	1
Hourly	0	1	1	0	0
Daily	0	0	0	0	0
Weekly	1	2	0	0	0
Monthly	8	13	0	0	1
Fixed Fee Contract	0	0	0	1	0
Other	2	2	1	5	1

Rates incorporate many elements, such as acuity of individuals served and/or geographic adjustment factors. These may be important factors for consideration in case management

²³ www.medicaid.gov/medicaid/hcbs/downloads/rate-setting-methodology.pdf.

²⁴ Home & Community Based Services Training Series, SOTA Rate Presentations found at www.medicaid.gov/medicaid/hcbs/training/index.html.

rate setting to ensure that, throughout the state, there are sufficient providers with the acumen necessary to effectively support individuals with all types of support needs. For example, many states include acuity factors when determining rates for case managers supporting individuals with complex support needs. In addition, states may include geographic variations within their rate structures to ensure that there is sufficient provider coverage across the state.

States must also determine the unit of payment in a fee-for-service environment. Units can be in increments that are sensible for the service delivered. For case management, there is wide variation across states (indeed, even within

states) on the units of service defined. Despite the commonality of fee schedules as a method of rate development, there is very little commonality across states, as illustrated in the table below. According to 21 states, monthly units of service and billing are the most common, followed by a 15-minute unit (NASDDDS survey).

Similarly, the actual rates paid by unit across states vary tremendously. As noted above, rates reflect the service scope, caseload, productivity assumptions, and myriad other factors contributing to the ultimate amount paid for service. Figure 5 below demonstrates the significant variances across states in the rates paid.

Figure 5. Case Management: Rate Ranges in Dollars per Unit

TIME	TCM	HCBS WAIVER	1115	Admin	(b)/(c)
5 minute	3.96-8.64	n/a	n/a	n/a	n/a
15 minute	10.86-50	11.73-23.62	n/a	n/a	23.17-23.62
Hourly	n/a	40 (1 response)	51	n/a	n/a
Daily	n/a	n/a	n/a	n/a	n/a
Weekly	310 (1 response)	184.34-310	n/a	n/a	n/a
Monthly	85.57-537	125-310	n/a	n/a	176 (1 response)
Fixed Fee Contract	n/a	n/a	n/a	1 contract at 7499	n/a
Other	771 for transitional case management	359 during transition period	169 average across 5 tiers	Variable based on contract	Variable

Rates can vary quite significantly within the same unit of service. Variance in rates for the same payment units often relates to the scope of activities covered by that unit of service. **Florida** uses multiple rates for their waiver support coordinators. Florida operates monthly

billing but payment rates and requirements for earning the monthly amount differ depending on the intensity of the case management services and the living arrangement of the individual. The same type of variation occurs when we attempt to compare rates among

states. The scope of responsibility, the intensity or complexity of supports, the qualifications of the provider, and the individual situation of the person served all factor into the scope of

responsibility and payment rate. This type of variation makes it difficult to compare rates among states unless you can match scope of responsibility.

Florida's contact requirements and rates for Support Coordination**

Full Support Coordination requires two billable contacts monthly. Rate is: \$148.69/month

- Supported Living - One face to face monthly and one additional billable activity. At least quarterly, the face to face has to be in the individual's home.
- Assisted Living Facility - One face to face monthly and one additional billable activity. Every other month, the face to face has to occur at the facility.
- Licensed Residential Facility - One face to face monthly and one additional billable activity. Face to face visit must be at the licensed residential facility each month.
- Family Home - One face to face every three months and additional billable activities. Every six months, the face to face has to occur at the residence.
- Independent Living - One face to face every three months and additional billable activities. Every six months, the face to face has to occur at the residence.

Enhanced Support Coordination is allowable for up to six months when an individual is transitioning from an institutional setting or new to the waiver due to a crisis situation. This service requires four billable contacts monthly. Rate is: \$359.83/month

- Two face to face visits monthly and additional billable activities. At least one of the face to face visits, must be at the residence. If transitioning from an institution, face to face visits must occur weekly during the first month after transition. After that month, the visits will be two visits monthly along with at least two other billable contacts monthly.

Limited Support Coordination requires one billable contact monthly. Rate is: \$74.35/ per month

- Family Home - Two face to face visits annually with one in the residence and additional billable activities.
- Independent Living - One face to face every three months and additional billable activities. Every six months, the face to face has to occur at the residence

**Courtesy of Lorena Fulcher
Florida Agency for Persons with Disabilities

A number of states recently engaged in significant rate restructuring, both in response to CMS rate reviews and structural changes in waiver case management that bring their system into compliance with the HCBS COI requirements.²⁵ **Wyoming** recently restructured its system to be conflict free (notably they started this effort before the HCBS rules even came into play). They then commissioned a rate study and developed new rates approved by CMS. A report on the rate methodology can be found at health.wyo.gov/wp-content/uploads/2018/02/WY-SFY-2019-DD-and-ABI-Waiver-Rate-Study.pdf.

States with rate setting initiatives underway, include Indiana, California, and Maryland. **Indiana's** request for proposal is available at www.in.gov/idoa/proc/bids/rfp-19-019/019_rfp%20Addendum%203.docx.

CMS has increased its emphasis on state practices for rate development for all services, including case management. It is important for states to have a clear and transparent method for rate setting and established timeframes for evaluating the rate methodology to ensure, as required by statute, that, "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers."²⁶

Each of the authorities available for the delivery of case management functions have their own specific requirements and operational considerations, including those pertaining to financing and reimbursement. These specifications may inform the authority that best meets the state's specific needs and/or

desired outcomes for the case management activities. Figure 6 below provides an overview of the various authorities employed to effectuate case management.

²⁵ A very good document on how Wyoming approached system redesign can be found at wyomingcsp.org/_pdfs/2013/WDHShortsummaryofwaiverredesign8292013.pdf.

²⁶ 42 CFR §447.204.

Figure 6. Authorities "At-a-Glance"

Authorities "At-a-Glance"	1915(c) HCBS Waiver	1915(g) Targeted Case Management	Administrative Claiming	Managed Care	1915(i) State Plan HCBS
Regulations	1915(c) of SSA 42 CFR §441.300 –310 §441.301(c)(1) (vi) (COI)	Section 1915(g) of SSA 42 CFR §440.169	1903(a) of SSA 42 CFR §433.15	1902(a) of SSA 42 CFR §438.54(c) 1915(b) and 1115 of SSA 42 CFR §430.25 Waivers of state plan requirements Managed care: 42 CFR §431, 433, 438, 440, 457, 495	1915(i) of SSA 42 CFR §440.182(c) 42 CFR §435.105(b) (COI)
Persons Who May Be Served	Medicaid eligible individuals who qualify for HCBS waiver program (i.e., individuals who meet level of care)	Medicaid eligible persons who meet the target group definition A state may operate multiple TCM programs for various groups No "institutional" need test	Medicaid eligible individuals for whom activities are performed by an administrative entity	Medicaid eligible individuals as described in 1115 approved application	Target group by age, diagnosis or condition, and/or Meets state-defined needs-based criteria that are "less stringent" than institutional level of care
FFP Rate	FMAP: service match rate	FMAP: service match rate	FMAP: 50% match rate	FMAP: service match rate FMAP 50% if use admin.	FMAP: service match rate

Authorities "At-a-Glance"	1915(c) HCBS Waiver	1915(g) Targeted Case Management	Administrative Claiming	Managed Care	1915(i) State Plan HCBS
Covered Activities	Services which will assist individuals in gaining access to needed waiver and other state plan services as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained Other activities defined by the state and approved by CMS	Services to assist individuals in gaining access to needed medical, social, educational or other services, including: Follow-up or monitoring an individual's progress or status Service plan development Monitoring to assure services are received Other activities as defined by the state and approved by CMS	Activities that promote the "proper and efficient" administration of the Medicaid state plan, including: Medicaid eligibility determination and redetermination Medicaid intake processing Preadmission screening Prior authorization Medicaid outreach Other Medicaid related activities as defined by the state and approved by CMS	Managed care case management may take multiple forms depending on what is planned by the state and approved by CMS. Case management activities may include "typical" functions or may be designed specifically to meet the intended outcomes of the managed care program(s)	Follows 1915(c) definition: Services which will assist individuals in gaining access to needed waiver and other state plan services as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained" Other activities defined by the state and approved by CMS

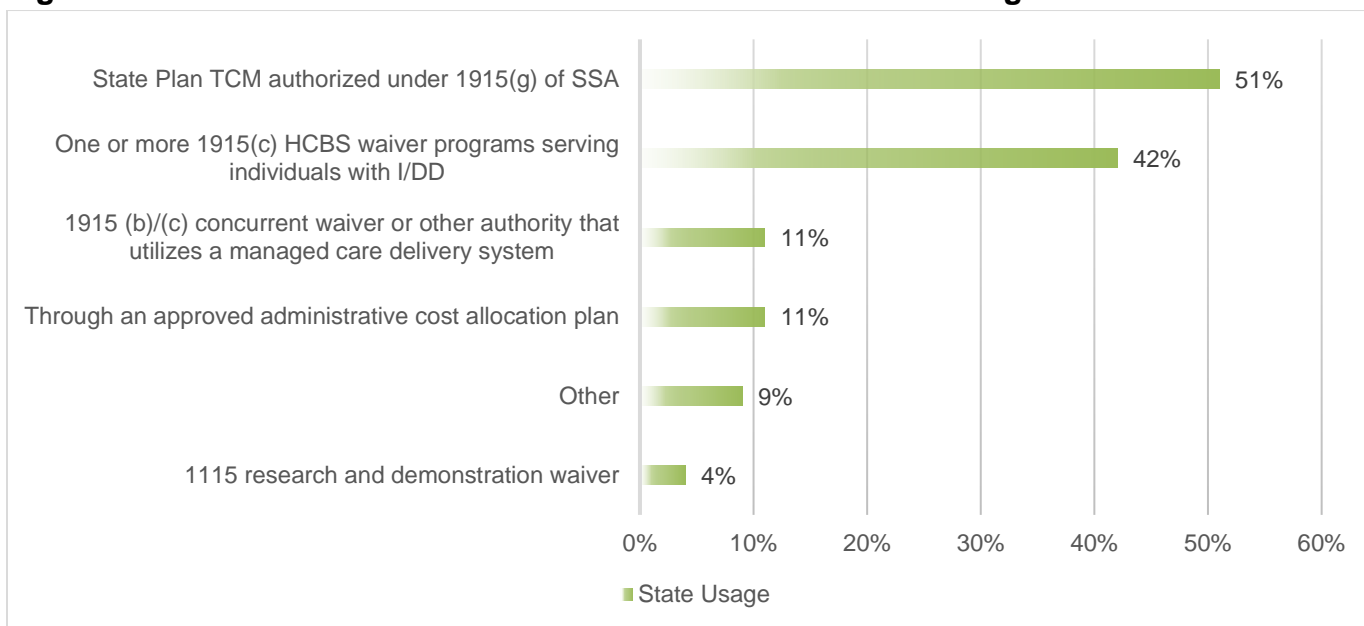
Authorities "At-a-Glance"	1915(c) HCBS Waiver	1915(g) Targeted Case Management	Administrative Claiming	Managed Care	1915(i) State Plan HCBS
Limitations	<p>Individual must be enrolled in HCBS waiver</p> <p>May not simultaneously claim for HCBS case management and TCM</p> <p>"Direct services" may not be furnished</p> <p>Must be conflict free unless "only willing provider" provision</p>	<p>TCM not allowed for institutionalized individuals, except 180 days before discharge</p> <p>Prior authorization activities cannot be conducted</p> <p>"Direct services" not permitted</p> <p>Must be conflict free when provided to individuals receiving Medicaid HCBS</p>	<p>FFP only available for assisting individuals to gain access to Medicaid services</p> <p>"Direct services" may not be furnished</p> <p>No individual right to services or selection of provider</p>	<p>Must meet eligibility and be enrolled in the managed care program</p> <p>May not simultaneously claim for case management as a managed care benefit and HCBS case management and/or TCM for the same person</p>	<p>Individual must be enrolled in state plan HCBS</p> <p>May not simultaneously claim for HCBS and TCM</p> <p>"Direct services" not permitted</p> <p>May not make eligibility determinations</p> <p>Must be conflict free unless "only willing provider" provision approved</p>
Providers	<p>Provider type & qualifications defined by state and approved by CMS</p> <p>Must offer freedom of choice of any qualified provider</p>	<p>Provider type & qualifications defined by state and approved by CMS</p> <p>May limit provider types to specific entities or organizations for persons with I/DD or chronic mental illness</p>	<p>Typically the state Medicaid agency</p> <p>May be performed by an entity other than the state Medicaid agency through an Interagency agreement or contracted entity/entities</p>	<p>Provider type & qualifications defined by state and approved by CMS</p> <p>May limit provider types to specific entities or organizations</p>	<p>Provider type & qualifications defined by state and approved by CMS</p> <p>Must offer freedom of choice of any qualified provider</p>

SECTION 3: MEDICAID FINANCED CASE MANAGEMENT OPTIONS

As shown in the *Authorities "At-a-Glance"* chart on the previous pages, states have multiple options available to finance case management services. Choosing the funding vehicle is a process of finding the best fit in terms of the population being served, scope of services, and the preferred provider types. And of course many states use multiple funding options as shown in the following information.

As the chart below demonstrates, targeted case management is the most utilized option among the 45 respondents to our NASDDDS survey. Twenty-three states use TCM in some fashion for people with I/DD, while 19 states use HCBS waiver case management. Survey respondents indicated five states use Medicaid administrative case management. In terms of managed care arrangements five states use a combination of 1915(b)(c) waiver to provide case management and two states use 1115 managed care arrangements to deliver case management. These data show that states often use more than one option, tailoring the use of these Medicaid financing authorities to specific populations.

Figure 7. State Use of Medicaid Authorities to Finance Case Management



1915(c) HCBS Waiver Core Service Definition

Case management under the HCBS waiver has no specific statutory definition. While waiver case management is considered a "statutory service," since it is mentioned as a coverable service in the statute governing the

program, no specific definition of the service appears in the HCBS waiver enabling statute. CMS provides a "core service definition," a straightforward iteration of typical case management activities, in the Technical Guide. While states are not required to adopt this specific definition, many states use it to build their case management definition. States have

the right to craft or modify their own definition for waiver case management submitted to CMS as part of the state's waiver application. But, of course, the state's case management definition is subject to CMS approval.

HCBS waiver case management is specific to the individuals enrolled in the Waiver, and thus cannot be used for non-waiver individuals or individuals enrolled in other waivers. CMS also reminds states that case management does not include the provision of what are deemed direct services. The Technical Guide clearly states, "The scope of case management services may not include activities/services that constitute the provision of direct services to the participant that normally are covered as distinct services."²⁷ Such activities or services include transportation, personal care, chore or other services that, if the state chooses to offer them, should have their own distinct service definition, provider qualification, and rate structure. As discussed in Section 5 below, individuals who serve as case managers are subject to the HCBS conflict of interest requirements as set forth in the HCBS regulations.

The Technical Guide provides the following core service definition: "Services that assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained."²⁸

The HCBS waiver application highlights these functions:

- Evaluation and/or re-evaluation of level of care;
- Assessment and/or reassessment of the need for waiver services;
- Development and/or review of the service plan;
- Coordination of multiple services and/or among multiple providers;
- Linking waiver participants to other federal, state, and local programs;
- Monitoring the implementation of the service plan and participant health and welfare,
- Addressing problems in service provision;
- Responding to participant crises; and
- For waivers with cost or service duration limits, monitoring to detect and resolve situations when the needs of an individual might exceed the limit(s) to ensure health and welfare of waiver participants.²⁹

The waiver case management definition highlights key activities for which the state is responsible and could elect to cover as part of case management. Again, CMS gives states considerable latitude in how they define case management. States may adopt the Core Services Definition in the Technical Guide, may modify the definition or devise their own state specific definition.

HCBS Waiver Case Management and Freedom of Choice

Freedom of choice, as required in statute at 1902(a)(23), is covered in substantial detail in the Technical Guide.³⁰ Waiver case management is treated in the same exact way as other services approved under the state's

²⁷ Technical Guide, p. 142.

²⁸ Ibid., p. 141.

²⁹ Ibid., p.105.

³⁰ Ibid., p. 99.

waiver. Thus individuals enrolled in the waiver must be afforded full freedom of choice among all willing and qualified providers of case management services:

When case management is furnished as a waiver service, a state may not limit the providers of case management to specific classes of entities (e.g., county human services agencies). All willing and qualified providers must be offered a provider agreement. Participants must be able to select from among all qualified providers.³¹

Medicaid regulations also require that all qualified providers be afforded a Medicaid provider agreement. This provider agreement enables them to bill Medicaid for the provision of the service for which they are qualified. Yet a state can also limit (the number of) providers. According to the Technical guide,

All qualified providers must be permitted to participate in the waiver program and have a provider agreement with the Medicaid agency if they chose to do so unless a state has secured a waiver of §1902(a)(23) to place restrictions on providers (e.g., by requesting a waiver under the §1915(b)(4) authority).³²

Ten percent of the states responding to the NASDDDS survey utilize a 1915(b)(4) waiver to limit the number of providers.

HCBS Waiver Case Management: Key Considerations

In terms of choosing waiver case management as the vehicle to serve individuals with I/DD features to take into account are:

- ✓ Waiver case management is available only to the specific individuals enrolled in the specific waiver.
- ✓ Reimbursement for waiver case management is only available as of the first day the person meets all waiver eligibility criteria and is enrolled in the waiver.³³ This means that in order to claim time the case manager put in to assisting the person before the first day of waiver eligibility, needs to be claimed either through another authority or amortized as startup costs into the rate paid for waiver case management. See Appendix 2 for information on claiming startup costs under the waiver.
- ✓ Waiver case management requires that individuals enrolled in the waiver have full freedom of choice of providers.
- ✓ Waiver case management is reimbursed at the service rate, that is, at the states federal medical assistance percentage rate (FMAP).
- ✓ States may use the core services definition available in the Technical Guide or craft their own definition for case management, subject to CMS approval.
- ✓ Covered scope of duties includes case management work with non-Medicaid individuals and entities *on behalf of* the waiver-eligible individual such as vocational rehabilitation agencies, schools, non-Medicaid practitioners or other contacts as is necessary to carry out plan of care.
- ✓ Waiver case management must comport with federal regulations and guidance on conflict of interest (Details in the COI section below).

³¹ Ibid., p. 142.

³² Ibid., p. 46.

³³ Earliest Eligibility Date in HCBS Waiver: www.medicaid.gov/Federal-Policy-Guidance/downloads/smd072500b.pdf.

Definition of State Plan Targeted Case Management (TCM)

Unlike waiver case management, targeted case management has a statutory definition. TCM requires the submission of a pre-printed state plan amendment (SPA) requesting permission to cover the service under the state plan.³⁴

The provisions of the TCM regulations permit states to select specific Medicaid-eligible groups for TCM eligibility. Unlike most other Medicaid benefits, which are an entitlement to all recipients based on medical necessity, states may limit TCM to specific sub-groups of

Medicaid eligible individuals. The state may also have multiple state plan amendments (SPAs) for differing target groups. As an example, states may use TCM for waiver recipients, indicating in their SPA that the target group consists of individuals enrolled in a specific waiver. As long as the state's use of TCM does not duplicate services, as described earlier, the state may use TCM for multiple groups of individuals. The TCM SPA Pre-Print requires that "Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose."³⁵

Section 1915(g) of the Social Security act authorizes the use of Medicaid for targeted case management:

(g)(1) A state may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A state may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, or to individuals described in section 1902(z)(1)(A) and a state may limit the provision of case management services under this subsection to individuals with chronic mental illness. *The state may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services* [Italics added].

(2) For purposes of this subsection, the term "case management services" means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.³⁶

³⁴ CMS TCM SPA Pre-Print template: www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/tcm-preprint.pdf.

³⁵ 42 CFR §441.18(a)(4).

³⁶ Sec. 1915 [42 U.S.C. 1396n].

The federal code of regulations builds on the Social Security Act, further defining the scope of case management services. 42 CFR §440.169 [abridged] reads,

- A. Case management services means services furnished to assist individuals, eligible under the state plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.
- D. The assistance that case managers provide in assisting eligible individuals obtain services includes -
 - 1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:
 - ix. Taking client history.
 - x. Identifying the needs of the individual, and completing related documentation.
 - xi. Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.
 - 2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:
 - i. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.
 - ii. Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.
 - iii. Identifies a course of action to respond to the assessed needs of the eligible individual.
 - 3. Referral and related activities.
 - 4. Monitoring and follow-up activities.
 - 5. Assuring:
 - i. Services are being furnished in accordance with the individual's care plan.
 - ii. Services in the care plan are adequate.
 - iii. There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
 - 6. Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.³⁷

³⁷ Excerpts from: 42 CFR §440.169.

The TCM regulations provide a wide-ranging definition that includes the key responsibilities of most case managers. Of particular note is provision (6), which permits collateral contacts, providing states a broader platform for establishing what consists of the billable contact. While certainly face-to-face contacts are essential, this provision facilitates billing for case management activities that beyond in-person or face-to-face meetings with the individual served.

In addition to the broad-based definition, TCM may be billed to support an individual transitioning from an institution to the community. It is permissible to bill for TCM up to 180 days before the date of transition to the greater community.

TCM and Access to Services

Medicaid regulations establish a particular protection requiring that individuals have access to but needn't accept services, including case management. Additionally, this regulation establishes the individual right to refuse case management yet still receive other services. This "Access to Services" requirement appears in the TCM services regulation but includes any case management services provided to the state plan.³⁸ It is our understanding that this requirement also applies to the HCBS waivers. As a condition of approval of the TCM SPA, the state must make three assurances:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.

This assurance intends to eliminate any type of "gatekeeping" by case managers. As discussed later in the COI section, case

manager decision making about individual resources or selection (choice) of providers may compromise their ability to advocate for the individual:

2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services.

The above provision that case management services do not "stand in front" of other services ensure that individuals cannot be compelled to receive case management in order to receive other services. While case management is typically pivotal for individuals to access services, the individual has the right to refuse it. CMS fully understands that case management activities are essential to gaining access to services. CMS has advised states that, if an individual refuses case management funded under the state plan, states have the option to support necessary activities such as assisting the person to find services, eligibility, and monitoring along with other typical case management activities, using the administrative claiming option:

3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

This provision regarding authorization of other services dovetails with conflict of interest requirements and reinforces that case managers are not gatekeepers. Freedom from authorization decisions fully allows the case manager to represent the individual in the

³⁸ Access to Services: 42 CFR §441.18(a)(2), 42 CFR §441.18(a)(3), 42 CFR §441.18(a)(6).

assessment of the person's needs and preferences.

TCM and Freedom of Choice

Generally, Medicaid services must meet certain overarching requirements with regard to freedom of choice of providers. States may request specific waivers of these requirements under certain conditions. TCM is rather unusual in that the actual regulations covering the provision of the benefit allow states to both limit the target group(s) served *and* allow states to limit the freedom of choice of provider for certain groups without a freedom of choice waiver.³⁹

In 1986, the Tax Reform Act added TCM as an optional state plan benefit. These regulations define case management as "an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual."⁴⁰

Section 9508 of P.L. 99-272 adds a new subsection (g) to §1915 of the [Social Security] Act, which amended by P.L. 100-203, provides that,

(g)(1) A state may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A state may limit the provision of case management services under this subsection to individuals with

acquired immune deficiency syndrome (AIDS); or with AIDS-related conditions, or with either, and a state may limit the provision of case management services under this subsection to individuals with chronic mental illness. The state may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.⁴¹

Also, 42 CFR §441.18 indicates,

(b) If the state limits qualified providers of case management services for target groups of individuals with developmental disability or chronic mental illness, in accordance with §431.51(a)(4) of this chapter, the plan must identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.

CMS added these provisions to the original legislation due to states' concerns that the freedom of choice regulation restricted the state from limiting case management to specific entities and/or individuals. Without this capability, states were unable to craft (or maintain existing) single point of entry systems which provide the essential roles of assuring appropriate access, oversight, and management of services. Thus these

³⁹ See section below for information on 1915(b)(4) Freedom of Choice Waivers.

⁴⁰ State Medicaid Manual, Section 4302. A.

⁴¹ §1915(g) of the Social Security Act.

provisions allow states to craft single point of entry case management systems that limit the qualified providers to specific types of agencies and/or individuals. Based on the NASDDDS survey, 23 states use TCM to finance case management to individuals with developmental disabilities. Many of these states use some type of single point of entry system such as a county, community services board, regional office or statewide and/or regional contracted provider agency. A single point of entry case management system provides a valuable structure for states to engage in more targeted oversight to assure consistent quality of case management as well as coordination and system management.

TCM and Freedom of Choice for Other Populations (non-I/DD or Mental Health)

Another important feature of TCM regulations is that the state may limit the case managers that provide the TCM benefit for individuals with chronic mental illness or with developmental disabilities as per 1915(g):

The state may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

And CFR 441.18,

(b) If the state limits qualified providers of case management services for target groups of individuals with developmental disability or chronic mental illness, in accordance with §431.51(a)(4) of this

chapter, the plan must identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.

CMS did this to assure that case managers are qualified to serve the specific target groups as well as allow for single point of entry case management systems. This provision allows states to construct provider qualifications and service system structures tailored to serve people with chronic mental illness and/or developmental disabilities.

1915(b)(4) Selective Contracting Waivers

With regard to other target groups such as individuals with physical disabilities or seniors, the state cannot limit providers under the TCM statute. However, a state may request a 1915(b)(4) Selective Contracting Waiver to restrict the providers from whom Medicaid eligible individuals may obtain services if they can demonstrate that "such restrictions do not substantially impair access to services of adequate quality where medically necessary."⁴² This statutory authority (as well as implementing regulations at 42 CFR §431.55) can be used in both fee-for-service as well as managed care arrangements.⁴³

If the state serves multiple target groups within one TCM SPA and wishes to limit the provider pool, the state may need to request the (b)(4) waiver. In some instances, CMS has required states to apply for a 1915(b)(4) freedom of choice waiver concurrently with their TCM

⁴² www.medicaid.gov/medicaid/managed-care/authorities/index.html.

⁴³ www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/1915b-4-ffs-tech-guide.pdf, p.3.

benefit.⁴⁴ The 1915(b)(4) waiver is required when the target groups covered in the TCM benefit include seniors or people with disabilities in addition to individuals with chronic mental illness or developmental disabilities. Therefore, if a state has combined populations (both individuals with physical disabilities and individuals with intellectual disabilities) in a 1915(c) HCBS waiver program, and uses TCM as the case management vehicle for waiver enrollees, the state would have to apply for a freedom of choice waiver in order to limit the provider pool under the TCM benefit.

TCM: Key Considerations

Unlike most other Medicaid benefits that are an entitlement to all recipients based on medical necessity, the provisions of the TCM regulations permit states to select specific Medicaid-eligible groups for TCM eligibility, i.e., target the benefit to a defined group. The regulations note that states may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS) or AIDS-related conditions or individuals with chronic mental illness.

On a practical, day-by-day basis there are no major differences between the case management activities furnished under TCM in comparison to those provided under an HCBS waiver program. Many states use TCM to serve individuals enrolled in HCBS waivers. TCM coverage allows the state to both target the benefit and define a more limited provider pool — that is, distinct from the "all qualified

providers" requirement by to the HCBS waivers. Additionally, TCM allows for Medicaid financing of case management for individuals outside the HCBS waiver program if the state chooses to include them in their TCM benefit(s).

- ✓ TCM regulations allow states to develop multiple options for case management targeting specific groups
- ✓ TCM requires the submission of a state plan amendment using a preprint
- ✓ TCM is an entitlement to the group(s) specified in the approved state plan amendment
- ✓ TCM can be used for individuals enrolled in a HCBS waiver
- ✓ TCM is reimbursed at the state FMAP rate
- ✓ TCM has a broad definition includes coverage of activities with generic and non-Medicaid providers and activities on behalf of the individual that do not require face-to-face contact
- ✓ One TCM SPA can be used to cover multiple populations, thus states could create a comprehensive, "umbrella" case management benefit
- ✓ When provided to waiver participants, TCM must comport with the conflict of interest requirements described earlier In this document
- ✓ Individuals have freedom of choice among qualified providers, but for individuals with chronic mental illness or developmental disabilities, the state may limit the provider pool in order to assure qualified array of providers

⁴⁴ Information on 1915(b)(0): www.medicaid.gov/medicaid/managed-care/authorities/index.html.

1915(b)(4) Pre-Print: www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/1915b4-ffs-application.pdf.

1915(b)(4) Technical Guide for the Application: www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/1915b-4-ffs-tech-guide.pdf.

Claiming Case Management Activities as an Administrative Expense

Defining Administrative Case Management Activities

In addition to the two options for providing case management as a Medicaid billable service detailed above, states may also opt to claim the cost of certain case management activities as a Medicaid administrative expense.

Medicaid administrative claiming does not have a specific definition like those for TCM or HCBS waiver case management. Rather it follows requirements for claiming state (and other designated entities') costs for carrying out administrative activities related to the Medicaid program. Medicaid administrative activities refer to those costs that are "as found necessary by the Secretary for the proper and efficient administration of the state plan."⁴⁵ The Secretary of Health and Human Services has final determination of which activities are allowable. In addition to case management activities, some common activities that fall under administrative claiming include:

- Medicaid eligibility determination,
- Medicaid intake processing,
- the prior authorization of Medicaid services (to the extent that a state requires this activity to be conducted in advance of furnishing a service),
- preadmission screening or level of care evaluations for persons being admitted to an institutional setting,
- Medicaid outreach activities, and

- the day-by-day costs incurred in operating the state Medicaid agency (SMA).⁴⁶

The Cost Allocation Plan

Administrative payments are not service payments. Unlike the payments for TCM or HCBS case management, the state does not claim for discrete services furnished to specific eligible recipients though they may structure their payments on a per-person basis. Rather, payments are made based on a cost allocation plan. There are varying rates of federal financial participation for administrative activities. For most part, these costs are shared equally between the state and the federal government (the federal matching rate is 50 percent).⁴⁷

In order to use the administrative case management option, the state needs to develop a cost allocation plan that lays out the activities claimed as an administrative expense. As with all these case management options, the SMA must submit their plan to use administrative case management to CMS for approval. CMS, in the Technical Guide reminds states to "Please note that cost allocation plans are not approved via approval of a 1915(c) HCBS waiver application."⁴⁸ The cost allocation plan process is not the same as a state plan amendment or a waiver action. The state should contact their CMS regional office to determine the best strategy for cost allocation plan development and approval.

⁴⁵ 42 CFR §433.15(b)(7).

⁴⁶ See www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD122094.pdf.

⁴⁷ 42 CFR §433.15 - Rates of FFP for administration.

⁴⁸ Technical Guide, p. 27.

Limitations of Administrative Claiming for Case Management

A critical feature of administrative case management is the all activities claimed must relate to managing, monitoring, or in some way overseeing Medicaid beneficiaries and services only. Therefore a case manager paid under Medicaid administration may only claim for time spent managing supports funded through Medicaid. Contacts with non-Medicaid providers or generic supports and services cannot be claimed as a cost under Medicaid administration. Activities such as assisting an individual to access employment supports through the vocational rehabilitation system, working with the school system, community recreation programs or other generic resources cannot be claimed under Medicaid administration. In addition, as noted above, Medicaid administrative claiming does not permit overhead costs as part of a cost allocation plan.

Administrative Case Management and Freedom of Choice

While there are limitations on what can be claimed as Medicaid administration, certain features make it attractive to some states. For example, Medicaid administration claims need not afford individuals full freedom of choice of all qualified providers. Administrative case management is not considered a direct service, therefore the regulations that apply to direct services are not applicable to administrative claiming.

It is at the discretion of the SMA (in consultation with any operating agency), with CMS approval, how case management will be delivered. The SMA has the authority to deliver the service themselves, bid out the service (if desired or required), or have the authority to "sole source" the case management activities to an entity that meets SMA requirements.

While state staff may perform these functions, administrative claiming may also be used to pay for case management furnished by an entity other than the SMA. When an entity other than the SMA, such as a state developmental disabilities agency, provides such activities, the SMA and the entity must enter into an interagency agreement spelling out the activities the entity will perform. Such agreements must be reviewed and approved by CMS's regional office. Under such agreements, the entity performs a function that the SMA would otherwise perform. The SMA must oversee the activities conducted under the agreement. Decisions made by the entity may always be appealed to the SMA. The types of entities that could provide administrative case management include other state agencies (including the state developmental disabilities authority), local entities such as public and private sub-state developmental disabilities authorities, and private provider entities. This option is particularly attractive to states where the administrative claiming amount is the same as the service reimbursement rates.

Administrative Case Management:

Key Considerations

- ✓ Administrative case management requires the development and submission of a cost allocation plan that must be approved by CMS
- ✓ Claimable administrative case management activities are limited only to individuals and services eligible under the Medicaid state plan
- ✓ Administrative case management does not require freedom of choice as it is not considered a service
- ✓ States may be able to "sole source" contracts for case management activities requiring certain qualifications or capacities

as determined needed to provide the activities

- ✓ Administrative case management may be provided by entities other than the SMA with SMA oversight
- ✓ Administrative case management documentation must demonstrate that the activities engaged in are those approved in the cost allocation plan and are for eligible Medicaid individuals or services
- ✓ Overhead costs cannot be claimed as a part of an administrative cost allocation plan

Managed Care and Case Management

As we noted earlier, a full discussion of case management activities within a managed care context is beyond the scope of this publication. Managed care approaches and authorities are quite varied, resulting in a multiplicity of innovations and waivers of Medicaid regulations. Within this publication we cannot do justice to how states design and implement case management activities within managed care programs.

Case management under managed care can take different forms depending on the purpose of the program and target populations. The managed care waiver or other managed care authority must outline who will perform a certain scope of duties and how. For example, case management for managed care medical services may only involve linking people among different health care providers. For people receiving HCBS through managed care, particularly when the program includes acute and/or behavioral health services, case management may focus on systems navigation and integration in support of individuals and

their families, as well as core case management functions generally found in 1915(c) waiver definitions.

When designing a managed care approach to HCBS, states have a variety of ways to provide for case management or (as described in managed care approaches) care coordination. Care coordination can focus on a limited set of activities (such as health care coordination) or be broadly defined to encompass the typical case management activities. As managed care programs expand to encompass HCBS services, states may seek differentiation or alignment between care management and case management, with some managed care contracts including both functions.

The state may choose to include case management activities under the managed care authority or use one of the other Medicaid authorities to provide case management to individuals enrolled in managed care programs. Therefore a state could choose to include case management activities as a covered service under the Medicaid managed care authority such as 1115.⁴⁹

Importantly, if the case management vehicle for the managed care program is a state plan authority outside of the managed care program (e.g., not included as an 1115 waiver service), such as targeted case management (TCM), the TCM definition and regulations listed earlier in this publication apply. The provisions of the TCM regulations permit states to select specific Medicaid populations and providers. As an example, a state may choose to use TCM under managed care for the sub-population of those eligible for Medicaid acute medical care,

⁴⁹ A good reference on the variety of Medicaid managed care approaches can be found at www.medicaid.gov/medicaid/managed-care/authorities/index.html.

who are not eligible for long-term services and supports, and use the 1115 authority to provide case management for those eligible for long-term supports and services.

Managed Care Case Management:

Key Considerations

- ✓ How will the state cover case management activities for individuals enrolled in managed care?
- ✓ Will case management be part of the managed care program, as an administrative expense, under the state plan, or as a combination of multiple options?
- ✓ Since care coordination/case management is not specifically defined in the managed care statutes, states will need to craft definitions that fulfill the intended objectives of the managed care program.
- ✓ If the state chooses both to deliver care coordination and case management, the state will have to be well aware of potential duplication of payment concerns.
- ✓ The state will need to work closely with CMS on case management design to assure it meets CMS expectations.⁵⁰

"Internal" Case Management

In conjunction with the delivery of a covered service, direct services providers may need to perform some functions that appear similar to case management but are effectually implementation activities necessary for the delivery of their particular service. For example, coordinating an individual's residential services and support plan within the residential provider agency is integral to the

delivery of the services. Therefore, these activities are part of the covered residential habilitation service. Coordinating medical appointments or scheduling transportation are all internal activities essential to the delivery of residential services. Similarly, a supported employment agency's activities in mapping out a training plan for an individual would be considered integral to the delivery of that service. These types of activities sometimes termed "internal case management" can exist side-by-side with Medicaid funding of "external" or "system" case management. From a federal policy perspective, the key consideration is for one set of activities to not duplicate the other. These functions are distinct from independent case management as they are specific to the providers' delivery of the services for which they are being compensated. These types of responsibilities are typically embedded into the services definitions and/or the provider agreement or contract as well as being covered in the payment rate made to the provider.

There are similarities and differences among the various authorities available for funding case management activities. Choosing which authority to use is an exercise in "best fit," that is, matching the authority to the structure and outcomes decided upon by the state and stakeholders.

System Structure and Choosing the Funding Authority

States can use whatever case management delivery system best suited to their state and stakeholders as long as the system comports with the Conflict of Interest regulations and the

⁵⁰ As of the date of this publication, CMS has not issued specific formal guidance on conflict of interest under managed care arrangements.

requirements of the chosen Medicaid funding stream. How a state designs the case management structure has implications for the roles and responsibilities of the state, providers, consumers, and families.⁵¹

In choosing the funding stream, the state and stakeholders need to weigh its requirements against the preferred system structure. For example, the state may decide to use its employees to provide case management to both Medicaid eligible and non-Medicaid eligible individuals. In this instance, administrative claiming may be a good option. Establishing a cost allocation plan that uses quarterly time/activity logging for documentation of staff activity may offer a streamlined and simple approach to covering the costs of the state staff. The trade-off is that administrative case management is only compensated at the 50% federal financial participation rate and activities not tied directly to a Medicaid eligible person and Medicaid eligible service would not be covered. Therefore the state would have to consider the impact of lower reimbursement and certain unclaimable activities. If the state's federal medical assistance percentage is high, administrative claiming may result in a loss in revenue that could adversely affect payment rates. The state will want to assess the financial impact of whatever authority they choose. The state will also want to consider the impacts of other requirements such as the full freedom of choice requirement under the HCBS waiver.⁵²

States that wish to craft a single point of entry system with a specific provider pool may find

that targeted case management is a good fit. As noted earlier, the TCM rules allow states to limit the provider pool for individuals with intellectual disabilities in order to permit single point of entry systems. For states that have regional case management entities, TCM may be a good option.

Waiver case management requires full freedom of choice of all qualified providers, which at times is of particular importance to stakeholders. Having multiple options for case management enables individuals to change case managers more easily. Having full freedom of choice does require state (or quality management designee) oversight and monitoring to assure that case management services are provided in consistently statewide. With multiple providers, the state may want to establish clear entry points into the services system. Including case management as part of the waiver benefit allows individuals and families to see a more cohesive "package" of services.

Clearly, there is no single correct answer for any state. Choosing the authority is an exercise in finding the best option(s) given the type of system and structure that the state and stakeholders determine best provide case management services.

⁵¹ See Section 5 for detailed information on the conflict of interest provisions in the HCBS rules.

⁵² The Kaiser Family Foundation maintains a current inventory of state FMAP rates at www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D.

SECTION 4: STATE DATA ON UTILIZATION OF MEDICAID FUNDING AUTHORITIES

States may use more than one option when serving individuals with intellectual and developmental disabilities. Yet the data do not represent some of the nuances of how specific states deliver case management. For example, one state claimed case management as cost under their 1115 waiver. Another state covered case management as an administrative cost under a 1915(b) waiver as well as a discrete state plan service under Early and Periodic Screening, Diagnostic and Treatment. The survey data represent a broad-brush picture of how states fund their case management activities utilizing a variety of authorities.

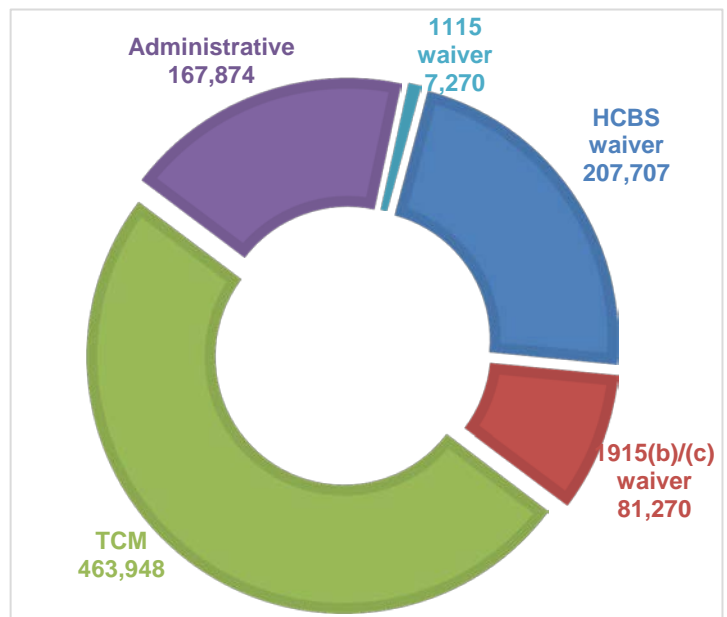
State Use of Medicaid Authorities

As portrayed in Figure 7 (p. 22), TCM is the most utilized option for funding case management to individuals with intellectual disabilities. TCM is often a good fit for states as it encompasses a reasonably flexible and wide array of activities and allows states discretion to define a provider pool and create a single point of entry system. The HCBS waiver also offers a significant source of funding for case management; nineteen states indicated they used HCBS waivers to fund case management activities. In addition to these two authorities, 16 states noted use of an alternative method for delivering case management. It is apparent from these numbers that states use more than one option. For example, one state has used TCM funding for case management to non-waiver enrollees and waiver case management for individuals enrolled in each of the state's waivers.

Aggregate Numbers Served by Type of Authority

Not only are TCM and the HCBS waiver the most common funding streams, it logically follows that these authorities serve the most people. The 45 survey respondent states served a total of 967,637 people utilizing the authorities below.

Figure 8. Number Served by Funding Authority



Again, among the responding state I/DD agencies, targeted case management is the most common financing option, and serves 463,948 individuals nationally as compared to less than half that number served through the HCBS waivers.

Use of Non-Medicaid Funding

Although the survey focused on the use of Medicaid financing for case management activities, NASDDDS did ask if states used other sources of funding for case management. Twenty-five states (56%) reported use of non-Medicaid funding for case management activities.

Figure 9. Use of Non-Medicaid Funding

While we did not assess the level of fiscal effort, states, counties, and localities continue to provide non-Medicaid matched funding for some case management activities. Survey data indicated that 21 states relied on state-only dollars, two states used county dollars and two others utilized other sources such as local dollars or Social Services Block Grant funds.⁵³

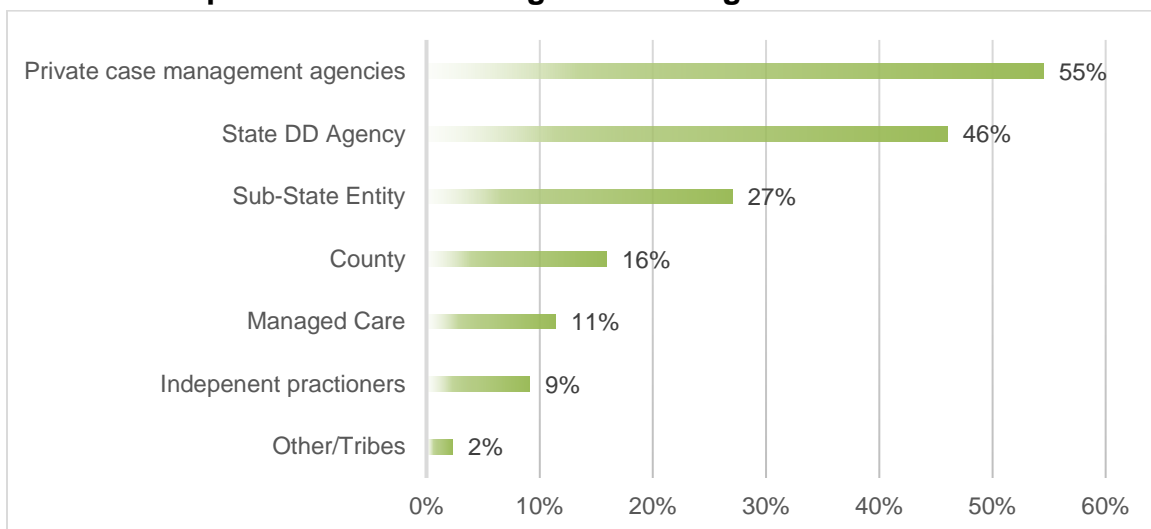
Entities Providing Case Management Services

States have significant latitude as to what types of entities or organizations provide case management activities. States may also

choose to qualify individual practitioners.⁵⁴ There are no federal regulatory requirements regarding how organizations constitute themselves. Nor are there CMS requirements regarding case managers' skill sets or educational backgrounds.

NASDDDS survey data show that the two most common case management provider types are state developmental disabilities agency personnel and private provider agencies. Twenty states reported using state personnel while 24 states report employed private provider agencies. Twelve states reported utilizing some type of sub-state entity such as a regional office or public health department and seven states reported a county-based system. The use of individual, independent practitioners is less common. Only four states reported the use of this type of provider. Given the reported data, some states use more than one type of entity.

Figure 10. Entities Responsible for Providing Case Management



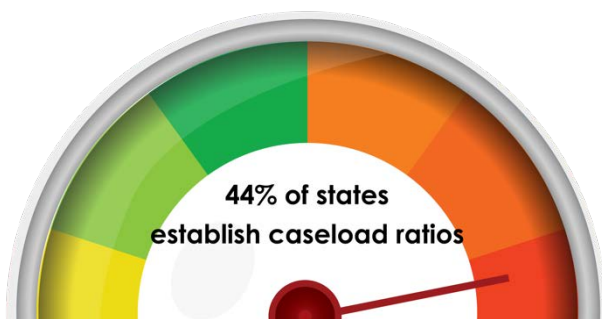
⁵³ For an explanation of the Social Services Block Grant see www.acf.hhs.gov/ocs/programs/ssbg.

⁵⁴ While independent case managers have met the Internal Revenue Service and Department of Labor requirements around what professions can be independent contractors/practitioners, states are encouraged to check the regulations regarding employer employee relationships both at their state and federal level. For information on these requirements, please see webapps.dol.gov/elaws/whd/flsa/docs/contractors.asp and www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-self-employed-or-employee.

Caseload Ratios

Determining the "right" caseload size is an enduring and knotty problem. No one standard fits all situations. Medicaid regulations do not prescribe specific caseload ratios or impose a limit on the number of persons that any given case manager may assist. Optimal caseload size depends on the scope of duties of the case manager, the intensity of needs of the individuals for whom the case manager provides support, the robustness of the services provided to the individual, and the extent to which the case manager has support from other professionals and paraprofessionals. In frontier states, the long distances the case manager travels influences caseload. In some states, caseloads may be determined through collective bargaining which can influence caseloads and payment rates. A case manager for behaviorally challenging adults, with comprehensive responsibilities ranging from assessment and planning to implementation and monitoring of the support plan, would likely operate a much smaller caseload than a case manager responsible for bi-annual check-ins for children living at home with stable, well-resourced families. Other factors, such as the absence of natural supports, intensive medical or behavioral needs, or a limited array of qualified providers influence the size of assigned caseloads.

Figure 11. Establishing Caseload Ratios



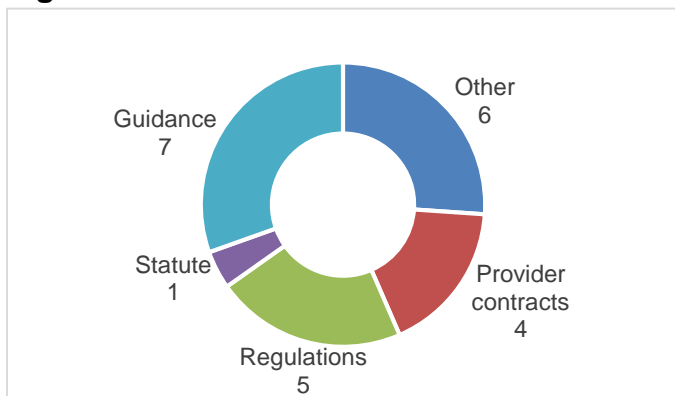
States have varying practices in establishing caseload ratios. In response to our survey question, 20 states (44%) indicated they set caseload ratios while 25 states (56%) have not. In many situations where caseload ratios were not set, the states established quality management and outcome expectations that case managers and their agencies must fulfill. This type of quality management expectation affects caseload sizes as the individuals and agencies cannot fulfill their quality and outcome requirements if caseloads become too large.

For states that set caseload ratios, the NASDDDS survey asked how the ratios were established. Seven states have established ratios through guidance, policies or bulletins; while six have done so through state regulations or statute. Four states have established caseload sizes through provider agreements.

Six other states have used a variety of methods to establish caseload ratios with either state staff or independent case managers, including:

- Using HCBS waiver guidelines to set ratios,
- Establishing the ratios through the rate-setting process,
- Establishing the ratios through the budget process, and
- Requiring ratios be established in provider agency operating procedures.

Figure 12. Methods to Establish Ratios



The NASDDDS 2006 case management report indicated that caseload sizes ranged from a low of 15 to a high of 100 clients per case manager, with an average national caseload across all the various case management options of about 40:1.⁵⁵ About half the responding states indicated that their caseloads were at 35:1 or below.

1: **20** 1: **75**

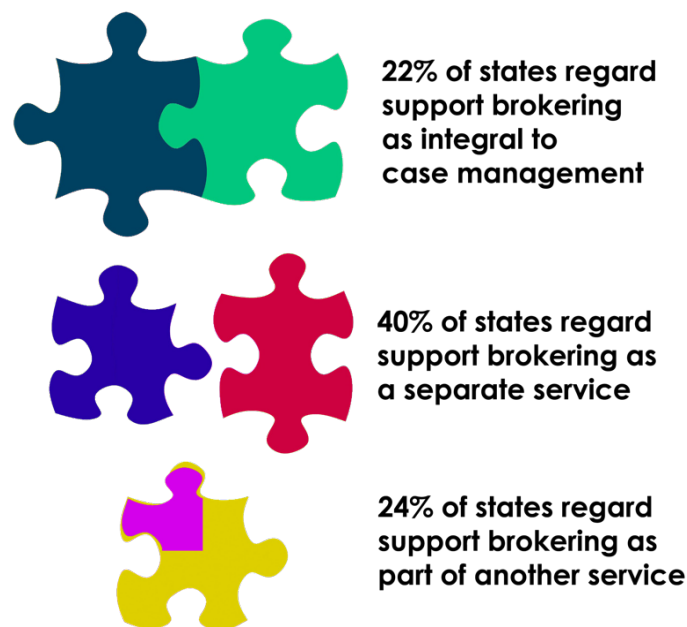
Our 2018 case management survey shows us that states use ratios from a low of 1:20 to a high of 1:75. Some states noted distinctions of caseload based on living situation, complexity of supports, and other factors. Ten states have caseload ratios of fewer than 1:35 individuals. Eight additional states have ratios in the range of 1:40 to 1:45.

The many factors that influence caseload size make it difficult to compare practices across states. At best, these data provide a means to "benchmark" a state's system rather than describe optimal practice.

Case Management and Support Brokering

Eighty-nine percent of respondents indicated they offer the option of self-directed services. Support brokering, assisting the individual to manage and direct their own services, is key to self-directed services.

Figure 13. Case Management and Support Broker Functions



As noted by CMS:

A supports broker/consultant/counselor must be available to each individual who elects the self-direction option. The supports broker/consultant/counselor supports the individual in directing their services, and serves as a liaison between the individual and the program, assisting individuals with whatever is needed to identify potential personnel requirements, resources to meet those requirements, and the services and supports to sustain individuals as they direct their own services and supports.
The supports broker/consultant/

⁵⁵ Cooper, Robin, *Medicaid and Case Management for People with Developmental Disabilities: Options, Practice and Issues; Second Edition*, NASDDDS, June 2006, p. 56.

*counselor acts as an agent of the individual and takes direction from the individual [italics added].*⁵⁶

In essence, support brokerage is designed to assist individuals or their designated surrogate with employer-related functions, such as hiring and managing staff, in order to be successful in self-directing some or all of the individual's needed services.

In response to the NASDDDS survey, 10 states indicated that case managers also provide the support brokering for individuals that self-direct their services. For the rest of the respondents support brokering was separate from case management services, and provided by fiscal management or stand-alone agencies. Support broker functions may not replace the role or perform the functions of a case manager. Support coordination involves the primary activities of locating, coordinating, and monitoring.

In states where case managers also act as supports brokers, they may confront competing priorities. As articulated in a still relevant 2004 article, "Case managers have often found it difficult to reconcile their competing responsibilities to the consumer, the service provider, and state or local government."⁵⁷ The article continued,

Organizations and government agencies that are implementing self-directed services are working to disentangle the existing duties of case managers to prevent obligations that the staff might have to an organization from compromising decisions they may make

or recommend regarding the person they are "supporting."⁵⁸

States may want to take these concerns into consideration when embedding support brokering into case management responsibilities, making sure the case manager has the time and supports in their own work to fulfill support brokering responsibilities. Taking on the functions of a supports broker — which may include hands-on training, assisting individuals to recruit workers, helping set up documentation service delivery, and assisting with quality — may be more time-consuming for the case manager and should be considered when establishing caseloads. Whether your state provides support brokering as a separate service or as part of case management, it should describe support broker functions in an informative, detailed, and accessible policy and procedures manual. This will ensure proper service implementation so self-direction can be a reality for those who choose it. For a good example, visit the **Missouri Division of Developmental Disabilities** website, which has a section dedicated to self-directed supports, including how to access support broker training and implementation strategies: dmh.mo.gov/dd/progs/selfdirect.html.

⁵⁶ Support Guidelines: www.medicaid.gov/medicaid/ltss/self-directed/index.html.

⁵⁷ Moseley, C., *Issues in Support Brokerage*, NASDDDS, July 2004.

⁵⁸ Ibid.

SECTION 5: CONFLICT OF INTEREST (COI) AND CASE MANAGEMENT: THE NEW STANDARDS

CMS published final regulations pertaining to home and community-based services (HCBS) on January 16, 2014. These rules became effective March 17, 2014. These new rules apply to Medicaid funded HCBS under the 1915(c) HCBS waiver, 1915(i) state plan HCBS, and 1915(k) the Community First Choice (CFC) option. These rules establish new standards for what constitutes home and community-based services and includes new requirements around person-centered planning and case management as well.

Brief Overview of the HCBS Rules

The final rule establishes a definition of home and community-based settings (HCB settings) based on the experiences of the individuals served as well as the location and physical characteristics of the setting. The regulation intends to assure that individuals have full access to community life and receive services in the most integrated setting. States are required to provide CMS with a transition plan on coming into compliance with these HCB settings regulations by January 1, 2022. This final rule makes other changes to the Medicaid HCBS authorities which:

- Allow states the option to combine waiver target groups;

- Establish requirements for person-centered planning under the HCBS waiver and state plan HCBS;
- Clarify the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates; and
- Require state to address conflict of interest (COI) in the provision of service planning and in the eligibility and assessment processes under certain authorities.

The home and community-based services (HCBS) COI regulations require state systems to remove and/or mitigate COI that could occur in the areas of eligibility determination, assessment, and person-centered service plan development. The details of the rules differ somewhat for each of the HCBS authorities, although all indicate that the provision of service planning by individuals or agencies that also provide direct services is a COI. *The rule makes no provision for a timeline to come into compliance* (unlike the settings portion of the rule); therefore, *the provisions are in force as of the effective date of the final rule*. In practice, CMS is willing to work with states to develop corrective action plans to meet the COI requirements.^{59,60}

What is the Definition of COI?

A common legal description of conflict of interest (COI) is a "real or seeming incompatibility between one's private interests and one's public or fiduciary duties."⁶¹ Private interest are "natural to any business interested in its own survival in a competitive

⁵⁹ See Ohio's information at dodd.ohio.gov/IntheNews/Documents/ConflictOfInterest.pdf.

⁶⁰ In addition to the COI requirements under the HCBS rules, states participating in the Balancing Incentives Program (BIP) must fulfill a systems structural requirement for conflict free case management (CFCM). The BIP manual and other guidance as well as the experiences of participating states may be illuminating as states re-design their systems to eliminate COI. Extensive information on BIP can be found at www.balancingincentiveprogram.org.

⁶¹ Black's Law Dictionary, Eighth Ed., 2004, Saint Paul, MN: Thomson West.

environment." For example, a provider might have an interest in maximizing revenue by increasing the number of people it serves, minimizing costs through service reductions or Improving its competitive position relative to others through promoting awareness of its service.⁶² Simply put a conflict of interest can arise when a person or party has two contradictory interests.⁶³

Applying these concepts to services planning, when the same entity both assists an individual to gain access to services and provides services to that individual, there is potential for conflict of interest. Conflicts may occur in critical areas such as assuring and honoring free choice of providers, overseeing quality and outcomes, and opening up the possibility of decision-making based on financial concerns. Medicaid (including all the HCBS authorities) requires that individuals have free choice of providers. Even within managed care networks, individuals still exercise choice. Where an agency provides both direct services and case management to the same individual, service "steering" may consciously or unconsciously occur, compromising freedom of choice.

Quality and outcomes conflicts occur when an agency or organization engages in "self-policing," having the responsibility to oversee its own performance. This situation may put a case manager in the difficult position of assessing the performance of co-workers and colleagues within the same agency and/or having to report concerns to their mutual supervisor or executive director.

Financial COI may create incentives for either over- or under-utilization of services (the person is "costing too much" or "we're not being paid enough"). Case managers may feel financial pressure to "steer" the individual to their own organization or retain the individual rather than promote choice of requested or needed service changes. Since COI has the potential to compromise choice, quality, and accountability, addressing COI is essential to person-centered systems.

The regulations regarding conflict of interest are found under 42 CFR §441.730(b) for 1915(i) state plan HCBS, 42 CFR §431.301(c)(1)(vi) for the 1915(c) HCBS waiver and 42 CFR §441.550(c) for 1915(k) CFC. These regulations lay out the specific parameters of what constitutes COI for each authority. While the regulations do not give a specific COI definition, they indicate the relationships and system structures that constitute a COI. It is also worthwhile to read the summary of public comments on COI and CMS's responses to those comments as this helps in the interpretation of the rules.⁶⁴

⁶² Booth and Griffin. *Addressing Potential Conflicts of Interest Arising from the Multiple Roles of Colorado's Community Centered Boards*, December, 2007, Muskie School of Public Service, p. 10.

⁶³ dictionary.thelaw.com/conflict-of-interest/.

⁶⁴ Searching the term "conflict of interest" in the *Federal Register* / Vol. 79, No. 11 / Thursday, January 16, 2014 / Rules and Regulations, will bring up all the comments and responses, starting on p. 2984.

Figure 14. Conflict of Interest Crosswalk

Chart developed under New Editions contract for CMS

Conflict of Interest Crosswalk	TCM	1915(c)	1915(i)	1115
Regulation	Section 1915(g) of the Social Security Act	Section 1915(c) of the Social Security Act	Section 1915(i) of the Social Security Act – especially 1915(i)(1)(E)	Section 1115 of the Social Security Act
Applicable rule COI citation	COI: §441.301(c)(1)(vi)	42 CFR §441.300-365 COI: §441.301(c)(1)(vi)	42 CFR §441.710 COI: 42 CFR §441.730(b)	Overall: 42 CFR §431.400-428 Nothing specific to COI
Other technical guidance	CMS HCB training series	Technical Guide CMS HCB training series	CMS HCB training series	
Must eligibility determination be independent of case management?	Yes, when provided to individuals receiving HCBS under 1915(c) or (i)	Yes	Yes	See requirements of authority in which service(s) originated
Must case management be independent from assessment?	Yes, when provided to individuals receiving HCBS under 1915 (i)	No	Yes	CMS guidance indicates case management for HCBS under a 1115 waiver is subject to COI rules ⁶⁵
Must case management be independent from service provision?	Yes, when provided to individuals receiving HCBS under 1915(c) or (i)	Yes, unless only willing and qualified provider option approved by CMS	Yes, unless only willing and qualified provider option approved by CMS	CMS guidance indicates case management for HCBS under a 1115 waiver is subject to COI rules
Requirement for only willing and qualified provider?	Yes, when provided to individuals receiving HCBS under 1915(c) or (i)	Yes	Yes	Must be in accordance with CMS approval of 1115 waiver terms and conditions

⁶⁵ www.medicaid.gov/medicaid/hcbs/downloads/final-q-and-a.pdf.

Conflict of Interest Crosswalk	TCM	1915(c)	1915(i)	1115
Firewalls between functions permissible?	Yes, if only willing and qualified provider option is approved	Yes, if only willing and qualified provider option is approved	Yes, if only willing and qualified provider option is approved	See requirements of authority in which service(s) originated
Grievance process; dispute resolution	Fair Hearing requirements at 42 CFR §431 Subpart E	Fair Hearing requirements at 42 CFR §431 Subpart E 1915(b)/(c) combo 42 CFR §438 Subpart H Dispute resolution when COI present: §442.301(c)(vi)	Dispute resolution when COI is present: §441.730(b)(5)	Fair Hearing requirements at 42 CFR §431 Subpart E Additional safeguards as determined in the terms and conditions and approved by CMS
State Oversight		42 CFR §441.302 (assurances) COI: §441.468	42 CFR §441.745 (state responsibilities & quality improvement) COI: §441.720; 441.730; 441.540; 441.555 (especially)	Oversight, monitoring and safeguards as determined in the terms and conditions approved by CMS

COI Regulations and Guidance

COI and the 1915(c) HCBS Waiver

Since the publication of the waiver application format in 2006, CMS has asked about COI, even though there was no statutory prohibition on agencies delivering both case management and direct services. However when this occurred CMS asked the state to describe the "safeguards to ensure that monitoring is conducted in the best interests of the participant."⁶⁶ CMS guidance now requires case management must comport with the conflict of interest requirements under 42 CFR §431.301(c)(1)(v) and (vi).⁶⁷

The COI provisions under 42 CFR §431.301(c)(1)(v) and (vi) *apply only to service plan development.*

§441.301 Contents of request for a waiver.

(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the state demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the state must devise conflict of

interest protections including separation of entity and provider functions within provider entities, which be approved by CMS. Individuals must be provided with a clear and accessible alternative resolution process.

The Technical Guide is an excellent source for understanding CMS COI expectations. It lays out in detail what states need to do if the entity or individual providing case management also provides direct services. The Technical Guide indicates that the state must have, "demonstrated that the entity is the only willing and qualified provider to develop the person-centered service plan."⁶⁸ CMS also provides guidance in their HCBS Training Series, consisting of webinars on key topics surrounding Medicaid HCBS.⁶⁹ In a webinar titled, "Conflict of Interest Part II and Medicaid HCBS Case Management," CMS indicates that the basis for using this option could be:

- Rural/frontier area [that] "naturally" limits the pool of available entities,
- Cultural considerations requiring expertise that limits the provider pool, or
- Linguistic considerations that require special competencies to effectively communicate with and serve certain populations.

In the presentation CMS notes that the state should provide supporting documentation for the request such as data showing the basis for a "rural" or frontier designation or information on linguistic/cultural competence needed. And

⁶⁶ Technical Guide, p. 187.

⁶⁷ Ibid., p. 142, 180-181.

⁶⁸ Ibid., p. 181.

⁶⁹ HCBS Training Series, www.medicaid.gov/medicaid/hcbs/training/index.html.

the state must assure capacity to meet safeguards described below.⁷⁰

In addition to their rationale, states must also describe the safeguards they will put in place to ensure individual participant rights as well as quality monitoring and oversight. When a state asks for the only willing and qualified option, CMS provides a set of review criteria that includes safeguards to mitigate any issues related to free choice of providers, frequency and duration of services, and participant rights. The Technical Guide also enumerates a set of actions the state must take:

1. Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
2. An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and process;
3. Direct oversight of the process or periodic evaluation by a state agency;
4. Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
5. Requiring the agency that develops the person-centered service plan to

administratively separate the plan development function from the direct service provider functions.⁷¹

CMS will then review the state's request and make a determination.

COI and the 1915(i) State Plan HCBS

The language for 1915(i) includes a significant level of detail as to how to mitigate COI. The COI requirements for 1915(i) go further than those for the 1915(c) waiver, explicitly addressing COI in eligibility determination, assessment, and service planning. The regulations are found at 42 CFR §441.715, 720 and 730.

One of the requirements of 1915(i) is the establishment of needs-based criteria to establish eligibility. These criteria lay out the individual's functional status and other individual characteristics like risk factors (e.g., a history of repeated inpatient stays). The needs-based criteria establish that individuals served in 1915(i) meet eligibility criteria that are less stringent than an institutional level of care. This broader 1915(i) eligibility as compared to the 1915(c) HCBS waiver is the central premise of 1915(i) — it decouples eligibility for HCBS from eligibility for institutional care. 1915(i) regulations stress that evaluation assessment and service planning must be done by an independent case manager, that is, a case manager who is not associated with an agency or entity that provides direct HCBS to the individuals for whom they provide case management.

⁷⁰ Conflict of Interest Part II and Medicaid HCBS Case Management, www.medicaid.gov/medicaid/hcbs/downloads/training/conflict-of-interest-hcbs-case-management-july2018.pdf, slide 26.

⁷¹ Technical Guide, p. 180.

The regulations at **§441.715 Needs-based criteria and evaluation** for eligibility determination state:

(d) Independent evaluation and determination of eligibility. Eligibility for the state plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of this subpart. The independent evaluation complies with the following requirements:

(1) Is performed by an agent that is independent and qualified as defined in §441.730. [Described below.]

1915(i) regulations require an assessment to ascertain the individual's needs in order to engage in the development of the person-centered plan. The assessment must also be performed by an independent case manager.

The regulations at **§441.720 Independent assessment** for performing assessments of individuals' needs include similar language:

(a) Requirements. For each individual determined to be eligible for the state plan HCBS benefit, the state must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. In applying the requirements of section 1915(i)(1)(F) of the Act, the state must:

(1) Perform a face-to-face assessment of the individual by an agent who is independent and qualified as defined in §441.730.

§441.730 Provider qualifications.

Conflict of interest standards. The state must define conflict of interest standards that ensure the independence of individual and agency agents who conduct (whether as a service or an administrative activity) the independent evaluation of eligibility for state plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan. The conflict of interest standards apply to all individuals and entities, public or private. At a minimum, these agents must be any of the following:

Related by blood or marriage to the individual, or to any paid caregiver of the individual.

Financially responsible for the individual.

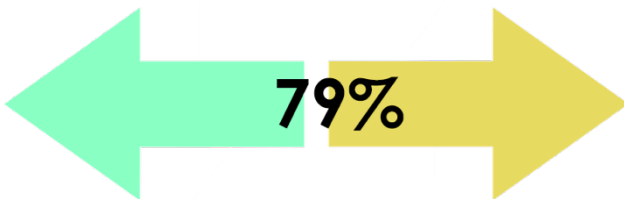
Empowered to make financial or health-related decisions on behalf of the individual.

Holding financial interest, as defined in §411.354 of this chapter, in any entity that is paid to provide care for the individual.

Providers of state plan HCBS for the individual, or those who have an interest in or are employed by a provider of state plan HCBS for the individual, except when the state demonstrates that the only willing and qualified agent to perform independent assessments and develop person-centered service plans in a geographic area also provides HCBS, and the state conflict of interest protections including separation of agent and provider functions within provider entities, which are described in the state plan for medical assistance and approved by the Secretary, and individuals are provided with a clear and accessible alternative dispute resolution process.

Of particular note is that CMS has applied the COI requirements to all providers, both public and private. CMS also applies the COI requirements to specific funding streams. Under 1915(i), CMS permits no COI in eligibility, assessment or service planning. This prohibition applies when using Medicaid service authorities such as targeted case management, 1915(i) case management or administrative funds. 1915(i) (like 1915(c)) bars providers of direct services to an individual from performing case management functions. However, 1915(i) goes further, barring certain individuals from becoming providers who are related by blood or marriage, bear financial or healthcare authority or responsibility over the person. These regulations are demonstrably more prescriptive than the 1915(c) HCBS waiver authority requirements.

Figure 15. State Systems with Conflict Free Case Management



Conflict of Interest and 1115 Waivers

As of the date of publication of this monograph, official guidance is not yet available on the issue of conflict of interest within 1115 research and demonstration waivers that cover case management services through managed care arrangements. In public meetings CMS indicated that if a managed care organization provides both care coordination (i.e., case management) and direct services, it may constitute conflict of interest. CMS has indicated that it would likely not be a conflict of interest if the managed organization or entity only provided care management and no direct services. At this time, we strongly suggest

states contact their CMS representatives for discussions about how conflict of interest interacts with managed care arrangements.

Addressing COI in Case Management System Design

While CMS regulations clarify expectations for addressing COI in state systems, the regulations do not prescribe any particular case management structure, provider type, provider qualifications or quality management structure. States have considerable latitude in designing case management systems that reflect local culture and stakeholder input.

The NASDDDS case management survey responses show overwhelmingly that a majority of states do not identify any conflict of interest in their case management systems. Seventy-nine percent of respondents indicated their system offered conflict free case management.

Twenty-one percent of respondents indicated there were conflicts of interest while seven states recognized both conflict free case management and situations with remaining conflicts of interest. In addition, a state may report a conflict of interest yet meet CMS's requirements under the "only willing and qualified" provider option. In this case, the COI may continue as the state has provided the required oversight and safeguards to mitigate it.

A number of states engaged in system redesign to mitigate conflicts of interest. COI may be identified by CMS during waiver renewals or by the states' own analysis of their system. South Dakota and Wyoming successfully redesigned their systems to eliminate conflict of interest in their case management systems. Each state has taken a different path crafted to meet the COI

requirements in a way that is responsive to stakeholder input. Both states worked intensively with their provider community and the community of individuals served to design a system that both comported with regulation and thoughtfully address the disruptions inherent in system redesign.

Wyoming embarked on a path to conflict free case management prior to the promulgation of the CMS rules. Their redesign resulted in permitting both individual and agency-based case managers, establishing full freedom of choice among any and all of the qualified providers. This strategy proved useful in a highly rural state as they were able to develop individual practitioners in the "frontier areas."⁷²

South Dakota chose a different route, procuring agencies with capacity to serve large rural areas. South Dakota made sure that there is at least a choice between two agencies in their regions. South Dakota did a particularly robust job of bringing individuals and families into the conversations around system change.

Alaska conducted an initial assessment to understand the scope and whereabouts of conflict of interest in their system across all populations. This assessment formed the basis of their comprehensive plan to assure their case management systems meet the COI regulations.⁷³

Ohio also embarked on a substantial redesign of their county-based system of supports and services serving individuals with I/DD. The County Boards of DD provide both case management and direct services as well as significant funding for the services system. Ohio's assessment of conflict of interest discovered more than 14,000 individuals who had received both case management services and direct services (day services mainly) from the County Boards. To redesign their system, Ohio developed a multiyear strategy to separate case management from direct services.⁷⁴

New Hampshire has engaged in a very thorough process to understand the scope of the conflict of interest, and its impact on individuals and providers. The state has mapped their agencies throughout the state to ascertain where conflict of interest may exist. The state has also worked closely with providers to assess how many individuals would have to change provider due to the new regulations. The state and providers also work together to understand the financial impact that coming into compliance with the rules would have on each agency in order to effect a smooth transition to the new system. Detailed information is available about their approach.⁷⁵

⁷² www.eiseverywhere.com/file_uploads/56ace8eae3cbaa12ca54411c43650a19_MakingtheTransition.pdf.

⁷³ dhss.alaska.gov/dsds/Documents/docs/CFCM_Report-FINAL.pdf.

⁷⁴

dodd.ohio.gov/InTheNews/Documents/ConflictOfInterest.pdf#search=case%20management%20and%20conflict%20of%20interest.pdf.

⁷⁵ www.dhhs.nh.gov/dcbcs/bds/hcbs-waiver.htm.

SECTION 6: CASE MANAGEMENT: CURRENT PRACTICE AND THE HCBS RULES

Roles of Case Managers

Agent of the Person/Agent of the State

Because case managers act both as an agent of the state human services system and an agent of the individual (and family), their responsibilities can lead to conflicts of interest and concerns about fulfilling both roles. As an agent of the state, case managers are the front line of monitoring, quality compliance, outcomes, and safety, acting as the "eyes and ears" for both the system and the individual. Case managers play essential roles in upholding key Medicaid requirements. They have central responsibility to ensure that paperwork is completed, which subsequently assures that resources (e.g., Medicaid funds) keep flowing and consequently people have the supports they need.

Key Case Management Functions

System Functions

- Oversight of provider performance
- Front line on quality compliance
- Monitoring and assuring individual outcomes
- Monitoring and assuring health and safety
- Upholding key Medicaid requirements such as:
 - informed choice and freedom of choice
 - assuring rights
 - assuring compliance with regulations
 - Keeping paperwork up to date
 - Keep funding flowing through
 - Level of care screens
 - CMS required annual reviews

- Assuring people keep financial eligibility for Medicaid
- Assuring individuals plans match billing...and much more

Individual and Family Functions

- Engage in high quality, person-centered planning that keeps the full focus on the person
- Be the frontline for information and assistance in figuring things out
- Be a source of knowledgeable and thoughtful strategies to help folks with what is important to them and for them
- Act as a "navigator" through the system on behalf of the individual and in consultation with the family
- Central person for solving system problems of outcomes and quality on behalf of the individual and family

As an agent of the person, the case manager's role consists of assisting people with disabilities and their families to plan for their future, and learn about and gain access to resources in their community. The case manager assures that people and their families receive the supports and services included in their plan, that the persons needs are met, preferences are honored and, as needs change, the individual plans and services change. Ultimately, the case manager helps to discover what matters most to the person and their family in order for them to have a good life.

Given these dual roles and critical responsibilities in navigating for the individual as well as monitoring provider performance, potential conflicts of interest have significant impacts. As described in Section 5, CMS established conflict of interest regulations that affect case management delivery and the

specific roles and scope of responsibilities permissible for case managers.

42 CFR §431.10(c) Determination of eligibility

(1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is — (i) The Medicaid agency; or (ii) The single state agency for the financial assistance program under title IV-A (in the 50 states or the District of Columbia), or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands.

And a specific prohibition: Before we delve into various case management activities, it is critical to note there is a significant limitation on what case managers are permitted to do. Federal regulations under 42 CFR §431.10 require that the state Medicaid agency (SMA) be responsible for eligibility determinations, which can only be delegated to another governmental agency with SMA oversight.⁷⁶ CMS require that eligibility decisions not be delegated to case managers as this may present a conflict of interest. The case manager may have a financial interest (more business for their agency), and may be protective of their own work (caseload is already too large). More likely, given the case manager's core role as an advocate, denying individuals' services may be a challenge incompatible with the intent of case management. While case managers may gather or provide information used in the determination of eligibility, eligibility determination cannot be a case manager responsibility.

CMS provides guidance on the scope of responsibilities of case managers in various webinars that can be found at www.medicaid.gov/medicaid/hcbs/guidance/index.html. Detailed guidance on conflict of interest can be found at www.medicaid.gov/medicaid/hcbs/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf.

Information and Referral

The intake and referral process is the first step in the case management process. Case managers typically spend considerable time during the intake process gathering information and talking with the person and their family to understand their current situation. This information helps determine what immediate steps need to be taken to assist the person. Additional assessments may also be conducted at the scheduled intake meeting to determine eligibility for additional services.

Case managers need to have broad knowledge of available community resources. Families often have very little information regarding supports and services, and depend on the case manager to assist them to support their immediate needs. This is especially important if the person is determined ineligible for the supports requested. When this occurs, it is important for case managers to have knowledge of other community resources and make the appropriate referrals.

Assessment

Individual assessment is a core function of case management. It may include both formal and informal protocols, tools, and instruments.

⁷⁶ Eligibility determination must be performed by the Medicaid agency or another agency specified in 42 CFR §431.10(c) with which the Medicaid agency has an agreement as provided in 42 CFR §431.10(d). Also, see Technical Guide, p. 293.

A case manager's role in the assessment process is to learn as much as they can from and about the person they are supporting, including the many aspects of their life that impact their choices.

Assessments also identify potential risks for the individual. In essence, the case manager will coordinate the overall assessment process to help the individual (and family) identify the comprehensive array of services and supports that are needed. The HCBS regulations specify that person-centered planning "is based on an independent assessment."⁷⁷ This requirement again reflects CMS concerns about conflict of interest, establishing that current and/or potential providers of direct services should not be performing the assessments used to establish the person-centered service plan.

Additionally the case manager should not be expected to perform assessments that result in fiscal decisions affecting individuals' resources.⁷⁸ Assessments used to set budgets or resource allocations can affect the choices, quantity, and ultimately the quality of supports people receive. These types of assessments by case managers may result in undue pressure about fiscal decisions. This pressure raises concerns for the case manager's role as advocate, as noted above and below (see section above Conflict of Interest (COI) and Case Management: The New Standards and below in Resource Allocation.)

The assessment process evaluates the person's need for medical, social, educational or other services. The assessment process includes such activities as identifying the needs of the person, completing related

documentation through review of formal assessment measures, and information gathered from other sources. The case manager will identify and document the need for supports through related documentation from the assessment process.

Assessments affect the person's life, health, and well-being. Therefore, gathering assessment information should be a flexible and comprehensive process that is best completed over several visits in order to collect enough information to fully understand the person's needs, preferences, and desired outcomes. In addition, as a person's needs and outcomes change, a new assessment may be in order.

Resource Allocation

Many states use resource allocation formulas to determine a person's needs for support. This process involves a service allocation method based on a person's characteristics, functional capabilities, and service utilization patterns. The goal of formula development is to be fair and equitable, and improve the distribution and equity of resources within and between populations. A best practice for case management is one where the case manager has no role in deciding on individual budgets or payments of any kind. Having case managers responsible for resource allocation decisions could be construed as a conflict of interest. As advocates for the person, case managers may feel pressured to increase budgets. Or, they may find themselves in the difficult position of assisting an individual to exercise their Medicaid Fair Hearing rights, possibly against themselves. Responsibility for financial

⁷⁷ 42 CFR §441.725.

⁷⁸ CMS-441.730-B; 42 CFR.

decisions puts the case manager in a problematic position and can compromise relationships, particularly if the individual or family feels the budget for resource allocation is inadequate.

Assessments for the purpose of resource allocation are best performed by an outside entity with no particular stake in the budget outcome. To assure no conflict of interest exists, a case manager's role in resource allocation should be limited to either, 1.) Assisting the individual to develop an individual support plan (that goes elsewhere for review), budget assignment, and approval, or 2.) Supporting the person to plan within their budget during the person-centered planning process. The case manager may also assist the individual in exercising their rights if the individual or family have concerns about the assessment and resource allocation process.

Person-Centered Planning

As noted earlier, 44 out of 45 states responding to the NASDDDS survey indicated they require case managers to be trained in person-centered planning. Clearly states have a strong commitment to person-centered planning across the nation. A review of the websites and materials states use for training reveals a variety of approaches and tools that have been developed both individually by states and nationally that align quite well with the HCBS requirements.

The goal of person-centered planning (PCP) is to empower individuals to build the life they choose or aspire to at any age across their lifespan. Person-centered planning is a unique and individual-focused approach that sets the foundation for getting to know an individual. It is a process that values what is truly important to a person and positions their strengths and

skills as the drivers for the development of personal outcomes.

PCP Process 42 CFR §441.725

- Is based on an independent assessment
- Is driven by the individual
- Includes people chosen by the individual
- Ensures that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions
- Is timely and occurs at times and locations of convenience to the individual
- Reflects cultural considerations of the individual
- Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient
- *Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants*
- Offers choices to the individual regarding the services and supports the individual receives and from whom
- Includes a method for the individual to request updates to the plan, as needed
- *Records the alternative home and community-based settings that were considered by the individual*

The PCP process identifies information about the person and summarizes all of the assessment results. The information the case manager derives from the PCP process becomes the basis for a person's roadmap to successful life outcomes based on their strengths and needs.

PCP is a process, which lays a foundation, but remains a fluid plan. As people grow, change, and move through their lives, many of the areas within their plan should change accordingly. The person-centered planning

process helps people achieve their life goals and evolves as the person's life evolves. The case manager revisits the plan throughout the year with the individual and family, helping them make critical decisions that affect their chosen life. The person-centered service plan should reflect the many factors that come into play in people's lives — their interests, age, and goals and aspirations throughout their life. The Centers for Medicare & Medicaid Services (CMS) have supported and invested in PCP for many years. CMS has issued a regulatory expectation for PCP as part of the package of HCBS related rules.⁷⁹ Person-centered planning is a requirement for all individuals receiving Medicaid funded HCBS. This applies to case management provided to individuals who receive HCBS that is funded through any of the authorities described earlier. There is an expectation that states already have person-centered planning embedded in their systems, as the regulation provided no future timeframe for compliance. CMS has indicated a willingness to work with states in establishing a timeframe to make these improvements. The rule specifies that when developing plans for those receiving supports through a Medicaid HCBS program under section 1915(c) and 1915(i) of the Act, the plans are required to be developed through a person-centered planning process. Also, in the Technical Guide CMS encourages and supports the use of person/family-centered planning methods in service plan development. Such methods actively engage and empower the participant and individuals selected by the participant in leading and directing the design of the service plan. This ensures that the plan

reflects the needs and preferences of the participant (and/or family, if applicable).⁸⁰

PCP Process

The new rules codify person-centered planning processes and define the contents of a person-centered plan in great detail, giving states and case managers opportunities for improving current practice.

While most of the requirements for the PCP process are familiar, the rules require states to establish policies, such as specific strategies for solving disagreements and guidance regarding conflict of interest. See Section 5 for details on how states have redesigned their systems to mitigate conflict of interest.

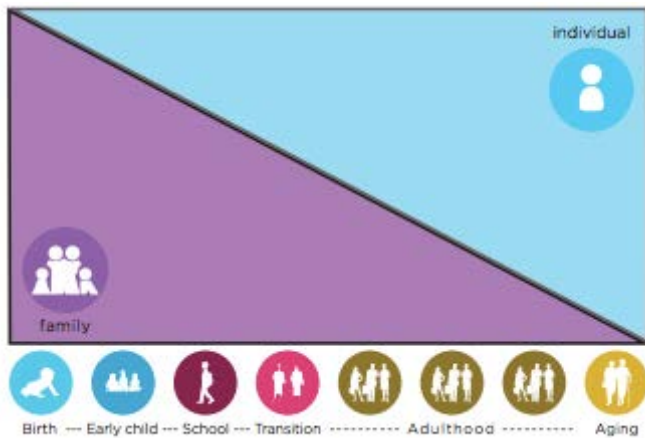
Another planning process requirement requires documentation of the variety of alternative home and community-based settings from which the individual may choose.

A number of states have built their PCP process to include both the CMS requirements found above as well as life course principles. The National Community of Practice for Supporting Families of Individuals with I/DD Across the Lifespan (COP) (funded by The Administration on Intellectual and Developmental Disabilities for six states and then expanded to 17) works across and within states to create policies, practices, and systems to better support families that include a member with I/DD. Participating states have changed their front door, shaped waivers, and partnered in other systems transformations.

⁷⁹ CMS–2249–F; CMS–2296–F; 42 CFR Part §441.

⁸⁰ Technical Guide, p. 178.

Figure 16. Supporting Families Community of Practice and Charting the LifeCourse Framework



The Charting the LifeCourse Framework™ (often referred to as the Supporting Families Across the LifeSpan Framework) endeavors to enhance relationships between support coordinators, individuals, and families as they plan to have good lives in the community. Through the **University of Missouri, Kansas City**, families created the Framework to help individuals and families of all abilities and ages to develop a vision for a good life. Additionally this framework offers a way for families to think about what they need to know and do, identify how to find or develop supports, and discover what it takes to live the lives they want. It provides a clear and creative approach to planning, builds on personal strengths and relationships, views the person in the context of the family, identifies supports within the community and system, and encourages meaningful conversations in planning.

Through the NASDDDS and UMKC supported National Community of Practice for Supporting Families, states are incorporating components of the Charting the LifeCourse Framework into their individual support planning processes.

Some of these state agencies include the **Indiana Bureau of Developmental Disabilities Services**, the **Connecticut Department of Developmental Disabilities**, and the **Missouri Division of Developmental Disabilities**, which have embedded the Framework into their quality measures.

Content of the Person-Centered Service Plan

Most state systems regulations comport with the CMS plan content requirements. That said, there are some current policies and practices that states need to change to comply with the PCP rules.

The requirement that the service plan "be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation" has led to some questions. In particular, case managers and other stakeholders, including state officials and providers, raised questions about the use of electronic signatures. With the advent of electronic health records and the new requirements for Electronic Visit Verification (EVV), states are using electronic signatures for a variety of applications.⁸¹ Although no specific guidance has been released regarding the HCBS rules and use of electronic signatures, in a 2004 letter CMS allows long-term care facilities to use electronic signatures if permitted by state and local law.⁸² The letter advises states to establish policies about what documents can be signed electronically and by whom.

States and self-advocates have raised privacy concerns in regard to the requirement that all

⁸¹ EVV guidance: www.medicaid.gov/medicaid/hcbs/guidance/electronic-visit-verification/index.html.

⁸² Electronic Signature Guidance, Ref. S&C-04-46, Survey and Certification Group, September 6, 2004.

providers of services sign the service plan. There was concern about certain vendors or individuals having full access to a person-centered plan. For example, it does not seem appropriate for a medical supplies vendor to be privy to information regarding a person's behavioral support plan. CMS has indicated that an appropriate, individualized approach to dissemination is a reasonable aspect of plan development.

PCP: Rights Modifications

Another significant requirement in the person-centered planning process is what CMS labels "modifications." Modifications are restrictions to a set of requirements that uphold specific rights for individuals living in what are deemed provider controlled settings, such as group homes, host homes or other residential programs where the provider both delivers the services and owns the premises.

In these settings, CMS iterated specific rights such as:

- tenancy agreements;
- lockable doors;
- choice of roommates;
- power to control one's own schedule;
- access to food; and
- the right to have visitors at any time.

Based on the individual assessment, there may be HCB settings requirements that pose a specific concern. For example, the right of access to food might prove problematic for individuals who have eating disorders. For others, a risk assessment may suggest that the right to certain choices could put the individual or others at risk or harm. These situations may necessitate "modifications" to the above individual rights. The regulation provides protections to individuals in provider-owned or controlled settings. Modifications to these

rights requires a series of steps be taken in the person-centered planning process.

To make a modification, first, the restriction must be supported by a specific assessed need and documented in the person-centered service plan. Prior to making any modifications, attempted but unsuccessful positive interventions and supports as well as less intrusive methods must be documented. A clear description of the person's condition that directly relates to the assessed need for modification must also be present along with the informed consent of the person. Restrictions must never cause any harm. States must assure freedom from harm. Any modification requires regular data collection to test its effectiveness.

PCP Modifications: Documentation

42 CFR §441.710(c)(4)(vi)(f)

Document that any modification of the additional conditions, under §441.710(a)(1)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.

The following requirements must be documented in the person-centered service plan:

1. Identify a specific and individualized assessed need.
2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
5. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include informed consent of the individual; and
8. Include an assurance that the interventions and supports will cause no harm to the individual.
9. Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

Tenancy Agreements Provider Controlled Settings

The tenancy agreement is a new requirement for some provider controlled settings.

Fundamentally, these agreements afford individuals in provider controlled settings the same types of protections from eviction and right of appeals as any tenant under existing state or local laws.

CMS gives states considerable flexibility in the design and implementation of the tenancy agreements. The **North Dakota Developmental Disabilities Division** created

a sample lease agreement that providers can use but also permits them to develop their own agreements that may include additional items.⁸³ **Colorado** has provided extensive training on landlord/tenant rights responsibilities and agreements.⁸⁴

Maryland Developmental Disabilities Administration developed a guide for their support coordinators⁸⁵ (whom they call Coordinators of Community Services) titled *Exploration and Discovery for Development of the Person-Centered Plan - A Guide* [sic] for the Coordinator of Community Services (CCS)*

⁸³ www.nd.gov/dhs/services/disabilities/docs/dd-provider-sample-lease-agreement.pdf.

⁸⁴ www.colorado.gov/pacific/sites/default/files/Residency%20Agreements%20and%20the%20HCBS%20Settings%20Final%20Rule-May%202016.pdf.

⁸⁵ dda.health.maryland.gov/Documents/PCP%20Guide%207-24-2018%20FINAL.pdf.

- *My Life, My Plan, My Choice...*, which includes a Rights Restrictions Summary Page. This summary page enables CCS to quickly see and review a summary of the identified risk, what positive and less intrusive measures have been tried, when and how the restrictive measure will be applied, and how often the team reviews the data to determine the modification's effectiveness.

Minnesota Department of Human Services, Disability Services Division, has also developed *A Provider's Guide to Putting the HCBS Rule into Practice*, which contains informational guidance, best practices, and examples to assist waiver service providers in understanding each of the new home and community-based services (HCBS) requirements.⁸⁶ This guide helps generating useful ideas for HCBS-compliant practices. It also has a section for health and safety rights modifications, which clearly lays out the responsibilities of both the provider and case manager as well as best practice suggestions and examples.

Modifications: Tenancy

42 CFR §441.710(a)(1)(vi)(A)-D

(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;

(B) Each individual has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;

(2) Individuals sharing units have a choice of roommates in that setting; and

(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;

(D) Individuals are able to have visitors of their choosing at any time;

Monitoring

Another key case management function is monitoring. According to the Technical Guide, "To assure participant health and welfare and the effective delivery of waiver services, active, continuous monitoring of the implementation of the service plan is an essential component of the waiver."⁸⁷ Monitoring ensures that waiver services are furnished in accordance with the

⁸⁶ mn.gov/dhs/assets/102517-hcbs-best-practices-guide_tcm1053-318393.pdf.

⁸⁷ Technical Guide, p. 186.

service plan; meet the participant's needs and achieve their intended outcomes. Monitoring is also conducted to identify any problems related to the participant's health and welfare that may require action. While ongoing monitoring of service plan implementation is most typically conducted by case management agencies, a state may specify other entities to perform it. States may also supplement service plan monitoring through other state monitoring activities such as licensing reviews or external quality reviews. The state may also conduct surveys of satisfaction with services, and review and analyze the use of behavioral interventions and/or psychotropic medications. The state may specify a minimum monitoring schedule and/or require that the monitoring schedule and methods are incorporated into each participant's service plan. The frequency with which monitoring is performed may vary based on participant risk factors.

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability, and other elements of waiver operations. In accordance with the HCBS Waiver Application,

Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves

desired outcomes, and identifies opportunities for improvement.⁸⁸

According to the Technical Guide,

The renewal of a waiver is contingent on CMS determining that the state has effectively assured the health and welfare of waiver participants during the period that the waiver has been in effect. In its application, the state must specify how it monitors performance in assuring health and welfare and the other waiver assurances by preparing and submitting a Quality Improvement Strategy.⁸⁹

The waiver assurances (and their component elements) must be included in the Quality Improvement Strategy. Case managers primarily have a role in the waiver assurances for health and welfare and for service plans:

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.⁹⁰

The waiver assurance for Service Plans requires that

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for the waiver participants.⁹¹

Each state describes the discovery, remediation, and improvement processes that it employs to ensure these assurances are met.

⁸⁸ Ibid., Appendix H.

⁸⁹ Ibid., p. 7.

⁹⁰ Ibid., p. 9.

⁹¹ Ibid.

Case managers have key monitoring responsibilities to fulfill these assurances. Case managers monitor progress made toward the outcomes identified through the person-centered planning process, which allows for tailoring supports throughout the lifespan. Case management monitoring provides support to participants and their families through frequent communication to assure current needs are well met and health and safety is upheld. Monitoring assures supports are appropriate and sufficient to create the quality of life envisioned by the individual, the family, and their community.

The HCBS waiver requires a sub-assurance that "Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan."⁹² Monitoring these plan elements also ensures participant access to services, has a current back-up plan, and exercises free choice of providers. Robust monitoring affords opportunities for discussion and planning surrounding increased or decreased support as changes in needs occur.

The Service Plan Implementation and Monitoring section of the CMS Home and Community-Based Waiver Application⁹³ requires states to specify the entities responsible for monitoring the implementation of the service plan and participant health and welfare. In most states a significant portion of these responsibilities fall within the scope of duties of case managers. Monitoring is typically conducted through face-to-face contact and phone conversations with the participant, family, and service providers or other entities

or individuals that are significant to either service delivery or the individual's personal circle. Face-to-face contact allows case managers the opportunity to (1) directly observe and engage with the people they support, (2) review the delivery of services and supports, and (3) ensure that the ISP is effectively implemented and adequately addresses the needs of the person, and whether progress towards outcomes specified in the ISP are being made. According to the Technical Guide, case managers must perform an annual review, but it is the state's responsibility to determine the frequency and intensity of monitoring required, as informed by the person-centered plan.⁹⁴

Having Conversations that Matter

Case managers are central to supporting people with I/DD and their families to have meaningful lives in the community. Part of this commitment is assisting individuals to find and sustain employment. Case managers are in the position to facilitate meaningful conversations that help individuals attain community integrated employment. The Americans with Disabilities Act (ADA) prohibits the discrimination of individuals with disabilities in employment, services, activities and programs. It requires supporting all individuals with disabilities so they have access to the most integrated setting in the community, enabling them to interact with people without disabilities to the fullest extent possible. The U.S. Supreme Court's *Olmstead* decision in 1999 reaffirmed the rights of all individuals with disabilities to full inclusion in their communities without unjustified segregation. Subsequent

⁹² Ibid.

⁹³ Ibid., Appendix D.

⁹⁴ Ibid., p. 186-187.

U.S. Supreme Court decisions and U.S. Department of Justice enforcement has focused on state and local activities regarding assurances of competitive employment in the community, career planning and eliminating the discriminatory overreliance on segregated day and employment services. CMS also issued an *Informational Bulletin* in 2011 highlighting available opportunities to use waiver supports to increase employment opportunities for individuals with disabilities within current policy.⁹⁵ This bulletin also underscored CMS's commitment to the importance of work for waiver participants and provided further clarification of CMS guidance regarding several core service definitions.

Employment and community inclusion are cornerstones of state policies and practices. Achieving these outcomes requires individuals to engage with community resources on an ongoing and consistent basis. It is critical for case managers to ensure individuals receive information about feasible employment opportunities; hence many states are focusing their efforts to enhance case manager competency in engaging conversations about employment at the front end of planning. These efforts are important so people have the ability to make informed choices based on experiences that lead to a pathway to employment. The NASDDDS survey revealed that 16 states require specific training for case managers on supporting individuals to become employed. Fourteen states have specific approaches for case managers to monitor and track employment progress and outcomes.

The New Jersey Division of Developmental Disabilities (DDD) has built in several checkpoints to ensure that case managers address employment by weaving it into the following components of their work.⁹⁶

- The [Pathway to Employment](#) tool provides the opportunity for the support coordinator to have a meaningful discussion about employment each year with the individual, their family, and other key members in their life.
 - A component within the tool facilitates and promotes probing discussion about an individual's position and understanding of employment.
- Process provides ample attention to meeting the individuals "where they are" (discussion component) and then follows up with requirements regarding setting goals and addressing barriers. All case managers in New Jersey must attend a two-day orientation that includes a segment devoted to employment, emphasizing values and expectations.
- It is mandated that at least one outcome in the ISP is related to employment.
- Case managers need to annually document where the individual is on their employment path.
- If the person is not pursuing employment at that time, DDD further reviews those ISPs to determine next steps.

When case managers are provided the necessary knowledge and resources, they can play a critical role in assisting people to realize valued outcomes including employment.

⁹⁵ Updates to the Technical Guide regarding employment and related services found at www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-16-2011.pdf.

⁹⁶ www.state.nj.us/humanservices/ddd/programs/employmentfirst.html#6.

PARTING WORDS

Case management encompasses a broad range of activities fundamental to every community service system. States have significant latitude in choosing the options for financing case management activities under the Medicaid program. Finding the fit among the goals and preferences of stakeholders; requirements for assessment, planning, and quality management; and regulatory requirements is obviously complex. But these Medicaid case management options provide multiple ways to structure case management systems, permitting states to craft systems that accommodate stakeholders and facilitate state accountability for the health, safety, and well-being of the people being supported.

The case manager's most important role is supporting individuals and their families. A case manager's initial encounter with individuals and their families is a pivotal first step in relationship building, expectation

setting, and the support and guidance of a trusted advocate along the pathway of life. The case manager has a continuing role to assist people with disabilities and their families to learn about and gain access to resources in their community, plan for their future, and assure that the person's preferences are honored as needs are met.

Case managers carry substantial expectations both from the people they support as well as the state agencies administering Medicaid programs. Ultimately, it is the case manager who must discover what matters most to the person and their family while simultaneously meeting system obligations to oversee programs, all to ensure people are receiving high quality services that uphold health and welfare.

As federal policy continues to shift and change, one thing remains the same: case management plays a vital role in supporting people and their families in having good lives as full members of their communities.

LIST OF APPENDICES

Appendix A	Acronym List
Appendix B	Start-up Costs
Appendix C	Olmstead Letter #3
Appendix D	Targeted Case Management Regulations
Appendix E	Frequently Cited Regulations and Guides

Appendix A: Acronym List

CFC	Community First Choice
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COI	Conflict of Interest
COP	Community of Practice
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community-Based Services
HCB	Home and Community-Based (Settings Rule)
HCFA	Health Care Financing Administration, now CMS
I/DD	Intellectual and Developmental Disabilities
ISP	Individual Support Plan
NASDDDS	National Association of State Directors of Developmental Disabilities Services
PCCM	Primary Care Case Manager
SC	Support Coordinator; Service Coordinator
SMA	State Medicaid Agency
SPA	State Plan Amendment
TCM	Targeted Case Management
1115	Research and Demonstration Waiver
1915(c)	Home and Community-Based Services Waiver
1915(i)	State Plan Home and Community-Based Services

Appendix B: Start-Up Costs: HCBS Waivers

Prepared by: Robin E. Cooper, Director of Technical Assistance, NASDDDS

Based on NASDDDS's understanding of CMS guidance, startup costs for services and training are allowable once the person enrolls in the waiver. For example, prior to the person's enrolling in the waiver, direct support staff may meet with the person to get to know them, incurring related costs. The cost of this time and/or training can be amortized into the rate paid to the provider once the person is eligible and enrolled in the waiver. For information on the criteria for establishing the earliest date of waiver eligibility and claiming for transition costs, including case management, see Appendix 3: CMS State Medicaid Director Letter, Olmstead Update no. 3.

States may choose to include startup costs in the provider payment rate. States will want to establish a means to verify these costs. Payment for these costs should be a part of the established, approved rate methodology.

General training costs are permitted as well but are typically included in the hourly, daily or monthly rate already paid the provider — i.e., the provider payment rate usually covers costs incurred to assure the workers are generally qualified and receive needed training and retraining over time. Typically routine training costs are "built in" to the rate paid a provider, understood as an ongoing cost of doing business rather than a one-time activity. CMS has a publication on this topic titled, *Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting: A Toolkit for State Medicaid Agencies*.⁹⁷

To eliminate cash flow issues, the state can use general funds to cover the provider startup costs prior to the individual's enrollment in the waiver. The state then pays the federal share once the person is enrolled in the waiver and Medicaid billing begins. Some states give the provider just the state share of the eventual Medicaid payment rate as a way to ease cash flow concerns and cover startup costs before the person is enrolled in the waiver.

With regard to billing case management costs (including support brokering), the State Medicaid Manual section 4442.3 B (b) (13) indicates,

When any service is provided as a waiver service, any client services which may precede the patient's eligibility for waiver services cannot be reimbursed unless, and until, the client becomes eligible for waiver services.

Again, Medicaid cannot be billed for the service until the person is enrolled in the waiver. However, this statement implies that case managers can cover startup costs as long as they are associated with an allowable waiver service and an eligible recipient. Unlike the waiver, if case management is provided through TCM, the state can claim the cost of transitional case management as long as it is part of their approved state plan amendment.

⁹⁷ National Direct Service Workforce Resource Center August 2013. Found at www.medicaid.gov/medicaid/ltss/downloads/workforce/dsw-training-rates-toolkit.pdf.

Waiver statute and regulations prohibit covering the costs of room and board. However, CMS has identified elements that may comprise transition services beyond room and board, such as basic household set up expenses and/or security deposits. A SMD letter on this service is attached.

Olmstead Update No. 3 provides the most information about billing startup costs for services once the person enrolls in the waiver:

- 1) **Targeted case management (TCM)**, defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community. We are revising our guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition. States may specify a shorter time or other conditions under which targeted case management may be provided. Of course, FFP is not available for any Medicaid service, including targeted case management services, provided to persons who are receiving services in an institution for mental disease (IMD), except for services provided to elderly individuals and children under the age of 21 who are receiving inpatient psychiatric services.
- 2) HCBS Case Management may be furnished as a service under the authority of section 1915(c) when this service is included in an approved HCBS waiver. Persons served under the waiver may receive case management services while they are still institutionalized, for up to 180 consecutive days prior to discharge. However, federal financial participation (FFP) is available as of the date the person leaves the institution and enrolls in the waiver. In such cases, the case management service begun while the person was institutionalized is not considered complete until the person leaves the institution and enrolls in the waiver. In these cases, the cumulative total amount paid is claimed as a special single unit of transitional case management. To claim FFP for case management services under the waiver, the state may consider the unit of service complete on the date the person leaves the facility and is enrolled in the waiver, and claim FFP for this unit of case management services furnished on that date. The cost of case management furnished as a HCBS waiver service must be estimated in factor D of the waiver's cost-neutrality formula.

Transition Costs

States may also elect to cover some costs of transitioning individuals from more restrictive to more integrated settings. CMS guidance now indicates this is not just available for individuals moving from institutions to the community but for those already in the community moving to more independent settings. The Technical Guide indicates,

In various State Medicaid Director Letters issued since 2000 (located in Attachment D), CMS has issued policy guidance concerning the provision of services for persons who transition from an institutional setting to the community. This guidance provides that certain services may be furnished in advance of the discharge of the person from the institutional setting and claimed for federal financial participation once the individual enters the waiver. The basis of

this policy guidance is to assure the continuity of services for individuals who are returning to the community. Community transition services may now be furnished to facilitate the transition of persons from any congregate setting (both institutional and non-institutional) to a more independent/less restrictive living arrangement.

All transition services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the waiver participant's service plan. States may not claim FFP for services that are furnished or activities that are performed in advance of the individual's entrance to the waiver, but may claim FFP once the person is enrolled in the waiver. If the individual should not enroll in the waiver due to unforeseen circumstances such as death or change in eligibility status, the State may be able to claim for some or all of the transition activities as administrative costs in accordance with an approved Medicaid cost allocation plan.

States have the flexibility to cover transition case management activities as either an HCBS waiver service or as targeted case management under the state plan. States are encouraged to include these transition services in their waiver programs. The relevant service specification should indicate when a service is furnished on transition basis.⁹⁸

⁹⁸ Technical Guide p. 122.

Appendix C: Olmstead Letter #3 EXCERPT

Department of Health & Human Services
Health Care Financing Administration
Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Olmstead Update No: 3

Subject: HCFA Update

Date: July 25, 2000

Dear State Medicaid Director:

This letter provides an update of the Health Care Financing Administration activities to support the Supreme Court's decision in *Olmstead* and the Americans with Disabilities Act (ADA) to enable individuals with disabilities to live in the most integrated setting appropriate to their needs. It also summarizes policy clarifications or policy reform designed to facilitate States' efforts to support the ADA.

On January 14, 2000, we transmitted the first in a series of letters describing the Supreme Court's decision in the case of *Olmstead v. L.C.* We observed the fact that Medicaid may be of great assistance to states in fulfilling their civil rights responsibilities under the Americans with Disabilities Act (ADA). We also promised to review federal Medicaid policies and regulations to identify areas in which policy clarification or modification would facilitate your efforts to enable persons with disabilities to be served in the most integrated settings appropriate to their needs.

This letter summarizes some of the recent Health Care Financing Administration (HCFA) efforts to review federal policies in order to facilitate fulfillment of the ADA. These efforts have been directed towards supporting States' initiatives in the following critical areas:

- Assisting people with disabilities to make a successful transition from nursing homes and other institutions into the community;
- Expanding the availability and quality of home and community-based services; and
- Ensuring that services are comparably available to all.

The attached enclosures consist of policy changes and clarifications that HCFA is making that will give States more flexibility to serve people with disabilities in different settings. These serve as guidance on how States may use the flexibility that Medicaid offers to expand services in a variety of ways.

We appreciate the ideas that you and members of the disability community have contributed so far. Most of the clarifications and policy reforms described in this letter emanate from your communications. We continue to invite new ideas because further policy work is required.

We have established an ADA/Olmstead website that contains questions and answers in response to inquiries received since the January 14th letter.

www.medicaid.gov/medicaid/ltss/downloads/community-living/smd-10-008.pdf

www.medicaid.gov/Federal-Policy-Guidance/downloads/11-010.pdf

We look forward to a continuation of our work together to improve the nation's community-based services system.

Sincerely,

Timothy M. Westmoreland
Director

Enclosures

cc:

All HCFA Regional Administrators

All HCFA Associate Regional Administrators

Division of Medicaid and State Operations

American Public Human Services Association

Association of State & Territorial Health Officials

National Association of State Alcohol and Drug Abuse Directors, Inc.

National Association of State Directors of Developmental Disabilities Services

National Association for State Mental Health Program Directors

National Association of State Units on Aging

National Conference of State Legislatures

National Governors Association

Enclosure

HCFA POLICY CHANGES AND CLARIFICATIONS ATTACHED TO THIS LETTER

Purpose: Assisting people with disabilities to make a successful transition from nursing homes and other institutions into the community

Policy	Clarification/Interpretation/Policy Change
Attachment 3-a: Earliest Eligibility Date in HCBS Waivers	Discusses a policy change regarding the earliest date of service for which Federal Financial Participation (FFP) can be claimed

Policy	Clarification/Interpretation/Policy Change
Attachment 3-b: Community Transition	Explains some of the ways that Medicaid funding may be used to help elderly people and individuals with a disability transition from an institution to a community residence
Attachment 3-c: Personal Assistance Retainer	Discusses a HCFA policy change indicating that a State may make payment for personal assistance services under a Medicaid HCBS waiver while a waiver participant is temporarily hospitalized or away from home

Purpose: Expanding the availability and quality of home and community-based service

Policy	Clarification/Interpretation/Policy Change
Attachment 3-d: Habilitation	Clarifies that habilitation services, including prevocational, educational, and supported employment services, are available under an HCBS waiver to people of all ages, in all target groups, if so specified by the State
Attachment 3-e: Out of State Services	Clarifies the circumstances under which Medicaid HCBS waiver services may be provided out-of-state

Purpose: Ensuring that services are comparably available to all

Policy	Clarification/Interpretation/Policy Change
Attachment 3-f: Services Provided Under a Nurse's Authorization	Clarifies that States may receive FFP for services provided at the authorization of a nurse, if the providers meet qualifications specified under the State Plan or Medicaid waiver for these services
Attachment 3-g: Prohibition of Homebound Requirements in Home Health	Notifies that the use of a "homebound" requirement under the Medicaid home health benefit violates Federal regulatory requirements at 42 CFR §440.230(c) and §440.240(b)

Attachment C-a

Subject: Earliest Eligibility Date in HCBS Waivers

Policy Change Date: July 25, 2000

This attachment describes the earliest date on which a person can be eligible for a home and community-based (HCBS) waiver service

Timely home and community-based services (HCBS) waiver eligibility determinations are particularly important to ensure that individuals awaiting imminent discharge from a hospital, nursing home, or other institution are able to return to their homes and communities.

Consequently, we have been asked to clarify the earliest date of service for which federal financial participation (FFP) can be claimed for HCBS and other State plan services when a person's Medicaid eligibility is predicated upon receipt of Medicaid HCBS under a waiver.

Under current Health Care Financing Administration policy, States must meet several criteria (described below) before they can receive FFP for HCBS waiver services furnished to a beneficiary who has returned to the home or community setting. For example, section 1915(c)(1) of the Social Security Act (the Act) requires that HCBS waiver services be furnished pursuant to a written plan of care.

Policy Change: To facilitate expeditious initiation of waiver services, we will accept as meeting the requirements of the law a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan of care is being developed and implemented. A comprehensive plan of care must be in place in order for waiver services to continue beyond the first 60 days.

The following chart summarizes the above and other requirements.

Earliest Date of HCBS Waiver Eligibility = The Last Date All of the Following Requirements Have Been Met

- 1. Basic Medicaid Eligibility:** The person is determined to be Medicaid-eligible if in a medical institution. The eligibility group into which the person falls must be included in the State plan.
- 2. Level of Care:** The person is determined to require the level of care provided in a hospital, nursing facility, or ICF/MR. Level of care determinations must be made as specified in the approved waiver.
- 3. Special Waiver Requirements:** The person is determined to be included in the target group and has been found to meet other requirements of eligibility specified in the State's approved waiver. These requirements include documentation from the individual that he or she chooses to receive waiver services. The person must actually be admitted to the waiver
- 4. Plan of Care:** A written plan of care is established in conformance with the policies and procedures established in the approved waiver. **Policy Change:** For eligibility determinations we will initially accept a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan

of care is being accomplished. A comprehensive care plan, designed to ensure the health and welfare of the individual, must be developed within this time

5. **Waiver Service:** The plan of care must include at least one waiver service to be furnished to the individual, and the State must take appropriate steps to put the plan of care into effect

When the eligibility determination has been made finding the individual eligible for the Medicaid HCBS waiver, the State may make a claim for FFP for services furnished beginning on the date on which all of these criteria are met. In subsequent attachments, we provide for special procedures to accommodate reimbursement for certain transition expenses that enable an individual residing in an institution to transition to community residence.

Any questions concerning this attachment may be referred to Mary Jean Duckett at (410) 786-3294 or Mary Clarkson at (410) 786-591.

Attachment C-b

Subject: Community Transition

Policy Change Date: July 25, 2000

This attachment explains some of the ways that Medicaid funding may be used to help elderly people and individuals with a disability make the transition from an institution to a community residence. We focus particularly on case management services, and removal of environmental barriers

Medicaid home and community-based services (HCBS) waivers are statutory alternatives to institutional care. Many States have found HCBS waivers to be a cost-effective means to provide comprehensive community services in the most integrated setting appropriate to the needs of the individuals enrolled.

Nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) likewise play important roles in our long-term care system. They are particularly important for short-term rehabilitation, sub-acute care, and crisis management that enable timely hospital discharge. However, short-term stays often become long-term residence when complicated planning is required for a return home, special housing or housing modification needs to be arranged, or exceptional one-time expenses must be paid.

This attachment explains several means by which Medicaid may assist States to overcome these barriers to community transition. It addresses the following:

- A. Case Management
 - 1. Targeted Case Management Under the State Plan
 - 2. HCBS Case Management
 - 3. Administrative Case Management
- B. Assessments for Accessibility
- C. Environmental Modifications
- D. Modifications Interrupted due to Death

A. Case Management. Case management services are defined under section 1915(g)(2) of the Social Security Act (the Act) as "services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational, and other services." Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community. There are several ways that case management services may be furnished under the Medicaid program:

1. Targeted Case Management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community. We are revising our guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition. States may specify a shorter time period or other conditions under which targeted case management may be provided. Of course, FFP is not

available for any Medicaid service, including targeted case management services, provided to persons who are receiving services in an institution for mental disease (IMD), except for services provided to elderly individuals and children under the age of 21 who are receiving inpatient psychiatric services.

2. HCBS Case Management may be furnished as a **service** under the authority of section 1915(c) when this service is included in an approved HCBS waiver. Persons served under the waiver may receive case management services while they are still institutionalized, for up to 180 consecutive days prior to discharge. However, Federal Financial Participation (FFP) is available on the date when the person leaves the institution and is enrolled in the waiver. In such cases, the case management service begun while the person was institutionalized is not considered complete until the person leaves the institution and is enrolled in the waiver. In these cases, the cumulative total amount paid is claimed as a special single unit of transitional case management. To claim FFP for case management services under the waiver, the State may consider the unit of service complete on the date the person leaves the facility and is enrolled in the waiver, and claim FFP for this unit of case management services furnished on that date. The cost of case management furnished as a HCBS waiver service must be estimated in factor D of the waiver's cost-neutrality formula.

3. Administrative Case Management may be furnished as an **administrative** activity, necessary for the proper and efficient administration of the State Medicaid plan. When case management is furnished in this fashion, FFP is available at the administrative rate, but may only be claimed for the establishment and coordination of Medicaid services that are not services funded by other payors for which the individual may qualify. 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.

When a state elects to provide case management as both an administrative and a service expense (either under the targeted case management state plan authority, or as a service under a HCBS waiver), the state must have a policy on file with HCFA that clearly delineates the circumstances under which case management is billed as either an administrative or a service expense. This information must be included in the supporting documentation that the state forwards with its state plan or waiver request.

Appendix D: Targeted Case Management Regulations

Title 42: Public Health

[PART 440—SERVICES: GENERAL PROVISIONS](#)

[Subpart A—Definitions](#)

§440.169 Case management services.

(a) *Case management services* means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with §441.18 of this chapter.

(b) *Targeted case management services* means case management services furnished without regard to the requirements of §431.50(b) of this chapter (related to statewide provision of services) and §440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.

(c) [Reserved]

(d) The assistance that case managers provide in assisting eligible individuals obtain services includes—

(1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:

(i) Taking client history.

(ii) Identifying the needs of the individual, and completing related documentation.

(iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.

(2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

(i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.

(ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.

(iii) Identifies a course of action to respond to the assessed needs of the eligible individual.

(3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or

other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

- (i) Services are being furnished in accordance with the individual's care plan.
- (ii) Services in the care plan are adequate.
- (iii) There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

(e) Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

[72 FR 68091, Dec. 4, 2007, as amended at 74 FR 31196, June 30, 2009]

§441.18 Case management services.

- (a) If a State plan provides for case management services (including targeted case management services), as defined in §440.169 of this chapter, the State must meet the following requirements:
- (1) Allow individuals the free choice of any qualified Medicaid provider within the specified geographic area identified in the plan when obtaining case management services, in accordance with §431.51 of this chapter, except as specified in paragraph (b) of this section.
 - (2) Not use case management (including targeted case management) services to restrict an individual's access to other services under the plan.
 - (3) Not compel an individual to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services.
 - (4) Indicate in the plan that case management services provided in accordance with section 1915(g) of the Act will not duplicate payments made to public agencies or private entities under the State plan and other program authorities;
 - (5) [Reserved]
 - (6) Prohibit providers of case management services from exercising the agency's authority to authorize or deny the provision of other services under the plan.
 - (7) Require providers to maintain case records that document for all individuals receiving case management as follows:
 - (i) The name of the individual.
 - (ii) The dates of the case management services.
 - (iii) The name of the provider agency (if relevant) and the person providing the case management service.
 - (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.
 - (v) Whether the individual has declined services in the care plan.
 - (vi) The need for, and occurrences of, coordination with other case managers.

- (vii) A timeline for obtaining needed services.
 - (viii) A timeline for reevaluation of the plan.
- (8) Include a separate plan amendment for each group receiving case management services that includes the following:
- (i) Defines the group (and any subgroups within the group) eligible to receive the case management services.
 - (ii) Identifies the geographic area to be served.
 - (iii) Describes the case management services furnished, including the types of monitoring.
 - (iv) Specifies the frequency of assessments and monitoring and provides a justification for those frequencies.
 - (v) Specifies provider qualifications that are reasonably related to the population being served and the case management services furnished.
 - (vi) [Reserved]
 - (vii) Specifies if case management services are being provided to Medicaid-eligible individuals who are in institutions (except individuals between ages 22 and 64 who are served in IMDs or individuals who are inmates of public institutions).
- (9) Include a separate plan amendment for each subgroup within a group if any of the following differs among the subgroups:
- (i) The case management services to be furnished;
 - (ii) The qualifications of case management providers; or
 - (iii) The methodology under which case management providers will be paid.
- (b) If the State limits qualified providers of case management services for target groups of individuals with developmental disability or chronic mental illness, in accordance with §431.51(a)(4) of this chapter, the plan must identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.
- (c) Case management does not include, and FFP is not available in expenditures for, services defined in §441.169 of this chapter when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following:
- (1) Research gathering and completion of documentation required by the foster care program.
 - (2) Assessing adoption placements.
 - (3) Recruiting or interviewing potential foster care parents.
 - (4) Serving legal papers.
 - (5) Home investigations.
 - (6) Providing transportation.
 - (7) Administering foster care subsidies.
 - (8) Making placement arrangements.
- (d) After the State assesses whether the activities are within the scope of the case management benefit (applying the limitations described above), in determining the allowable costs for case management (or targeted case management) services that are also furnished by another federally

funded program, the State must use cost allocation methodologies, consistent with OMB Circular A-87, CMS policies, or any subsequent guidance and reflected in an approved cost allocation plan.

[72 FR 68092, Dec. 4, 2007, as amended at 74 FR 31196, June 30, 2009]

Title 42: Public Health

[PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION](#)

[Subpart B—General Administrative Requirements](#)

§431.51 Free choice of providers.

(a) *Statutory basis.* This section is based on sections 1902(a)(23), 1902(e)(2), and 1915(a) and (b) and 1932(a)(3) of the Act.

(1) Section 1902(a)(23) of the Act provides that beneficiaries may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.

(2) Section 1915(a) of the Act provides that a State shall not be found out of compliance with section 1902(a)(23) solely because it imposes certain specified allowable restrictions on freedom of choice.

(3) Section 1915(b) of the Act authorizes waiver of the section 1902(a)(23) freedom of choice of providers requirement in certain specified circumstances, but not with respect to providers of family planning services.

(4) Section 1902(a)(23) of the Act provides that a beneficiary enrolled in a primary care case management system or Medicaid managed care organization (MCO) may not be denied freedom of choice of qualified providers of family planning services.

(5) Section 1902(e)(2) of the Act provides that an enrollee who, while completing a minimum enrollment period, is deemed eligible only for services furnished by or through the MCO or PCCM, may, as an exception to the deemed limitation, seek family planning services from any qualified provider.

(6) Section 1932(a) of the Act permits a State to restrict the freedom of choice required by section 1902(a)(23), under specified circumstances, for all services except family planning services.

(b) *State plan requirements.* A State plan, except the plan for Puerto Rico, the Virgin Islands, or Guam, must provide as follows:

(1) Except as provided under paragraph (c) of this section and part 438 of this chapter, a beneficiary may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is —

(i) Qualified to furnish the services; and

(ii) Willing to furnish them to that particular beneficiary.

This includes an organization that furnishes, or arranges for the furnishing of, Medicaid services on a prepayment basis.

(2) A beneficiary enrolled in a primary care case-management system, a Medicaid MCO, or other similar entity will not be restricted in freedom of choice of providers of family planning services.

(c) *Exceptions.* Paragraph (b) of this section does not prohibit the agency from —

(1) Establishing the fees it will pay providers for Medicaid services;

(2) Setting reasonable standards relating to the qualifications of providers; or

(3) Subject to paragraph (b)(2) of this section, restricting beneficiaries' free choice of providers in accordance with one or more of the exceptions set forth in §431.54, or under a waiver as provided in §431.55; or

(4) Limiting the providers who are available to furnish targeted case management services defined in §440.169 of this chapter to target groups that consist solely of individuals with developmental disabilities or with chronic mental illness. This limitation may only be permitted so that the providers of case management services for eligible individuals with developmental disabilities or with chronic mental illness are capable of ensuring that those individuals receive needed services.

(d) *Certification requirement* —

(1) *Content of certification.* If a State implements a project under one of the exceptions allowed under §431.54 (d), (e) or (f), it must certify to CMS that the statutory safeguards and requirements for an exception under section 1915(a) of the Act are met.

(2) *Timing of certification.*

(i) For an exception under §431.54(d), the State may not institute the project until after it has submitted the certification and CMS has made the findings required under the Act, and so notified the State.

(ii) For exceptions under §431.54 (e) or (f), the State must submit the certificate by the end of the quarter in which it implements the project.

[56 FR 8847, Mar. 1, 1991, as amended at 67 FR 41094, June 14, 2002; 72 FR 68091, Dec. 4, 2007]

Appendix E: Frequently Cited Regulations and Guidance

Social Security Act

TITLE XIX - GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

www.ssa.gov/OP_Home/ssact/title19/1900.htm

Code of Federal Regulations-Medical Assistance (Medicaid)

TITLE 42 - Public Health, CHAPTER IV - CENTERS FOR MEDICARE & MEDICAID SERVICES,
DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

SUBCHAPTER C - MEDICAL ASSISTANCE PROGRAMS

www.ecfr.gov/cgi-bin/text-

[idx?SID=8c901d22b11de84faa3d011fc160b05b&mc=true&tpl=/ecfrbrowse/Title42/42cfrv4_02.tpl#0](http://www.ecfr.gov/cgi-bin/text-idx?SID=8c901d22b11de84faa3d011fc160b05b&mc=true&tpl=/ecfrbrowse/Title42/42cfrv4_02.tpl#0)

Medicaid State Plan Amendments

www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html

1915(c) HCBS Waiver Application and Technical Guide

Application for a §1915(c) Home and Community-Based Waiver [Version 3.6, Includes Changes Implemented through January 2019] Instructions, Technical Guide and Review Criteria, Version 3.6

wms-mmdl.cms.gov/WMS/faces/portal.jsp

1915(c) HCBS Waiver Regulations

Section 1915(c) of the Social Security Act

42 CFR 441.300-310

Medicaid Case Management (general)

42 CFR 441.18

Targeted Case Management

Section 1915(g) of the Social Security Act

42 CFR §440.169

Administrative Claiming

Section 1902() of the Social Security Act

42 CFR §433.15

www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD122094.PDF

Freedom of Choice

Section 1902(a)(23) of the Social Security Act

42 CFR §431.52(a)(1)
42 CFR §431.51(b)(1)

Access to services

42 CFR §441.18(a)(2)
42 CFR §441.18(a)(3)
42 CFR §441.18(a)(6)

Managed Care information

www.medicaid.gov/medicaid/managed-care/authorities/index.html

Selective Contracting Waiver

Section 1915(b)(4) of the Social Security Act

1915(b)(4) pre-print: www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/1915b4-ffs-application.pdf

1915(b)(4) Technical Guide for the Application: www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/1915b-4-ffs-tech-guide.pdf

Home and Community-Based (HCB) Settings Rule

Regulation

Federal Register: 2014 Jan. 16;79(11):2947-3039., 42 CFR Parts 430, 431, 435, 436, 440, 441 and 447, and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers

www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

HCB Setting Defined

42 CFR § 441.530 Home and Community-Based Setting (defined)

Conflict of Interest

COI Regulations Applicable to Specific Funding Authorities

1915(k) Community First Choice 42 CFR 441.540 (a)(5)

1915(i) State plan HCBS 42 CFR 441.730

1915(c) HCBS waiver: 42 CFR 441.301(c)(1)(vi)

Targeted Case Management §441.301(c)(1)(vi)

42 CFR 441.301(c)(1)(vi) requires that providers of HCBS for the individual must not provide case management activities or develop the person-centered service plan.

42 CFR 431.10 requires that the State Medicaid Agency (SMA) be responsible for eligibility determinations, and eligibility determination can only be delegated to another governmental agency with SMA oversight.

CMS Guidance on COI

www.medicaid.gov/medicaid/hcbs/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf

www.medicaid.gov/medicaid/hcbs/downloads/training/conflict-of-interest-hcbs-case-management-july2018.pdf

Person-Centered Planning

Process: 42 CFR §441.725

Modifications to rights: 42 CFR §441.710(c)(4)(vi)(f)

Tenancy 42 CFR §441.710(a)(1)(vi)(A) - D

CMS Guidance on Person-Centered Planning

www.medicaid.gov/medicaid/hcbs/downloads/training/steps-creating-a-person-centered-planning-system.pdf

