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Sustaining Nursing Home Transition Programs: Covering Case Management Services

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Background

The Centers for Medicare and Medicaid Services has made 33 grants to states and Independent Living Centers to help nursing home residents move to the community. As these three year grants approach their final phase, grantees are exploring options for continuing their activity once their grants have ended. Two major issues have emerged: securing funds to support transition expenses and covering case management activities under other Medicaid authority. A conference call was organized on November 10, 2003 by the Rutgers Center For State Health Policy/National Academy for the State Health Policy Community Living Exchange Technical Assistance Exchange. Mary Jean Duckett, Acting Deputy Director of the Disabled and Elderly Health Programs Group, discussed the primary options for covering case management. There are five options states may use to cover case management under Medicaid:

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

The first three options are relevant to nursing home transition grantees and were discussed on the conference call.

1. 1915 (c) home and community based services waivers

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

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

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

Advantages

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

Disadvantages

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

[1] Case management services may be delivered prior to enrollment in the waiver but FFP may not be claimed until enrollment.

2. Optional targeted case management services

Targeted case management (TCM) is defined as "services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational and other services." TCM is a state plan service and has no connection to HCBS waiver participation. TCM may be furnished to nursing home residents who are preparing to move to the community. Like the 1915 (c) waiver, TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay. States may specify a shorter time period or other conditions under which targeted case management may be provided.

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

Advantages

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

Disadvantages

- States may not limit access to providers of case management services, except as specified above, for individuals with developmental disabilities or chronic mental illness.

3. Administrative activity

Case management may be reimbursed "as a function necessary for the proper and efficient operation of the Medicaid State plan." The payment rate is either the 50 percent matching rate or the 75 percent FFP rate for skilled professional medical personnel, who are employed in State or local agencies other than the Medicaid agency who perform

duties that directly relate to the administration of the Medicaid program. As an administrative activity, case management must be related to covered Medicaid services and do not cover gaining access to other services such as housing, food stamps or other non-Medicaid services.

In cases where workers perform activities funded under multiple auspices, careful records must be kept to document the State's claims for Federal funds under the appropriate authorities. Administrative case management activities may be performed by an entity other than the single State agency. However, there must be an interagency agreement in effect.

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

Advantages

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

Disadvantages

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