

Case Management: Implications of Recent Federal Activities

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Medicaid and Case Management: What Happened and Why?



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Administration's Medicaid Priorities

- 1) Rein in federal health spending
- 2) Assure Medicaid program and fiscal integrity
 - States pay full matching share with “legitimate” public funds
 - Closer scrutiny of provider claiming
 - Closer scrutiny of rate setting
 - A more “fundamentalist” approach to Medicaid benefit and eligibility definitions

CMS Goals

- “Make Medicaid look like commercial health insurance.”
- “Medicaid should not be a financing option for other public systems for non-Medicaid purposes.”
- “Target areas of rapid spending growth.”

Focus of Increased Scrutiny

- Use of inter-governmental transfers (IGT), certified public expenditures (CPE) & provider taxes
- Administrative claiming & refinancing of “health related” services through Medicaid
- Rates paid to public providers
- Bundled rates

Case Management

- CM and TCM* have become a major source of funding in some states for MH services (and services in MR/DD, foster care, juvenile justice, schools)
- CMS saw significant state spending growth; believed states were “abusing” optional service to claim excess federal funds

* TCM allows states to provide CM services to specific groups and/or (if MI or DD) designate specific providers

Federal Guidance

■ State Medicaid Director letters

- 7/25/00: states can use CM to assist people transitioning from institutional settings – last 180 days in institution
- 1/19/01: defines CM components as assessment, care plan development, referral, monitoring & follow-up; CM does not include direct services; states can target CM to members of social services programs; Medicaid only liable if no other 3rd party liable

State Plan Amendments

- CMS began to demand significant changes from some states as a condition of approval of CM/TCM proposals
- States either “gave in” or saw SPAs stalled for months, years
- CMS began to review “anything on the page” of a SPA

Medicaid Reforms

By 2005, Administration seeking budget and other vehicles to formalize wide variety of reforms

- Proposed capping administrative match to states (budget)
- Proposed limiting use of provider taxes (Deficit Reduction Act)
- Proposed limiting use of rehabilitation and TCM (Deficit Reduction Act)

DRA '05

- Defined Case Management and adopted some Administration-proposed limits on TCM
 - Components include assessment, care plan development, referral, monitoring & follow-up
 - Cannot include direct services
 - Specifically excludes activities relating directly to provision of foster care services
 - Medicaid liable only if no other 3rd party liable
 - Allocations across federal payers: OMB Circular A-87

DRA '05

- Medicaid Integrity Program funded by Congress
- CMS charged with providing leadership, state oversight, increased provider audits
- States incentivized to adopt false claims acts consistent with federal standards
- Providers, contractors must train staff in “whistle-blower” provisions

Budget Assumptions

2008 federal budget (2/07) proposed to address “inappropriate financing mechanisms”

- Legislative proposals - result in \$1.9 b in Medicaid savings in FY 2008; \$13 b over five years
- Administrative proposals - \$1.5 b in Medicaid savings in FY 2008; \$12.7 b over five years

It's Raining Regulations!

- CMS proposed 10 new regulations in first six months of FFY 2008
- Most issued as either “interim final” or with shortened public comment periods
- CM/TCM regulations took effect March 31, 2008

TCM Regulations Went Beyond DRA

- TCM/CM as *comprehensive: must include all 4*
- Only one Case Manager per person
- Billing in “15 minute units”
- Limited days of TCM/CM for community transition, based on length of stay (paid only after transition)
- Won't pay for Medicaid CM if delivered by employee of child welfare system
- Prohibited administrative CM

State View: TCM One of Several Harmful Regulations

- Eliminate school transportation, administration
- Restrict public provider reimbursement
- Eliminate graduate medical education
- Restrict out-patient hospital reimbursement
- Restrict provider taxes
- Restrict case management
- Restrict rehabilitation option

States Turned to Congress

- Congress has to find funding to delay or overturn administrative changes (Pay-Go: President's budget savings assumptions are the baseline)
- Congressional leaders believe states have “gamed” federal funds
- Congress doesn't really understand Medicaid impact

Moratorium Enacted

- Congress included moratorium on CM/TCM (and other regulations) until April 1, 2009
- Moratoriums had bipartisan support of Governors and obtained a veto-proof majority in both chambers
- Results of alliance of states, providers, advocates across Medicaid, MH/SA, aging, DD, public education and human services systems

Federal Clarification

- CM/TCM law, policies in effect before December '07 still bind state policy
- Economic & efficient rates, non-duplication of services & payments
- Consumer free choice of providers
- States may withdraw proposed SPAs – *or voluntarily pursue reforms*

After March 2009?

New Administration or Congress will need to act to:

- Extend moratorium or
- Propose modified regulations
 - 15 minute billing units
 - CM for transition planning
 - Single case manager

Contact Us

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